Maternal and Child Health Services
Title V Block Grant

State Narrative for Kansas

Application for 2011
Annual Report for 2009

Document Generation Date: Thursday, September 30, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

To obtain a copy of the signed Assurances and Certifications, contact:

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Over seventy individuals and organizations were invited to provide input into the MCH Block Grant five year needs assessment process. The group reviewed past priorities and activities undertaken to address them. They reviewed current data and selected new priorities. All of the materials generated through this process were placed on a website along with workplans for the coming year. Listserv's were used to advertise the availability of the website for public comment: Kansas MCH Advisory Council, CSHCN, Families Together, local health departments, school nurses, and other.

Dear Maternal and Child Health (MCH) stakeholders:

Thanks to those of you who participated in the five-year MCH needs assessment and planning meetings these last few months.

This spring, KDHE Bureau of Family Health staff developed logic models based on information provided by stakeholders during the November 2009 and January 2010 meetings. In completing the planning process, some priorities and strategies were modified based on expected capacity and available resources to implement over the next five years.

We wanted to give you a special invitation to review the latest results online if you haven't already. Go to this page to see the MCH 2015 priorities, strategies, and logic models: http://www.datacounts.net/mch2015/results.asp

On behalf of Linda Kenney and the KDHE Bureau of Family Health, we welcome your comments, suggestions, and questions! Thank you again for your interest and work in improving maternal and child health in Kansas.

For a copy of other comments received, please contact lkenney@kdheks.gov.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

From Fall 2009 through Spring 2010, a Panel of Experts collaborated in the Kansas 5-year needs assessment (MCH2015). Approximately 20 BFH staff along with 64 external stakeholders participated. As part of the initial planning process, they identified the mission and vision of MCH2015, adopting the mission of the BFH as the that of the MCH 2015. Vision: Healthy Children in Healthy Families, Mission: Provide leadership to enhance the health of Kansas women and children in partnership with families and communities

The Panel reviewed data, determined potential priorities, identified strengths and weaknesses, noted current partnerships and initiatives, assessed available resources and capacity, and identified potential strategies for the selected priorities. After initial priority selection and strategy identification, BFH staff developed logic models and action plans for implementing each priority. In mapping out the implementation specifics, some priorities and strategies were refined based on available resources and assessed capacity.

Key considerations woven into multiple levels of the planning process, including priority and strategy selection, were the 10 essential MCH services and these core values: prevention and wellness, social determinants of health, life course perspective, and health equity. Throughout the process, meeting notifications and handouts, data presentations, and interim results were posted on a public website: www.datacounts.net/mch2015. See Section IV B for state priorities selected.

Kansas' strengths and needs are very similar to those identified during the last 5-year needs assessment. Thus, there are many similarities in the resulting priorities. For the pregnant women and infants population group, the three priority need topics from 2010 were kept for 2015, but reworded slightly. One priority was added related to mental and behavioral health. Prioirites for the children and adolescents group changed the most from MCH2010 to MCH2015. A priority on healthy weight was the same for MCH2010. The injury and death priority was dropped, and the behavioral/mental health priority was narrowed to reduction of ATOD risky behaviors. A medical home priority was added. For the CYSHN group, the priority topics from MCH2010 were the same, though they were reworded and refocused for MCH2015.

The State MCH program and system capacity is also similar to that of the last 5-year needs assessment. However, the recent economic downturn, state budget challenges over the last several years, and increasing program responsibilities have demanded that Title V staff and its partners do more with fewer resources. Additional MCH-related advisory groups have been formed, resulting in better forums for communicating with stakeholders and strengthening partnerships, but these require more Bureau resources and staff time to participate and support. With budget pressures expected to continue in the future, an effort was made to select priorities that complement versus duplicate the efforts of other partners and where a significant improvement is achievable over the next five years such as childhood injuries, which Title V will continue to support.

During MCH2015 versus MCH2010, more time was devoted to identifying specific strategies and action steps for implementation, including the development of logic models for each priority need. Title V staff are committed to strategically maximizing current capacity and limited resources to ensure Kansas' priority needs are addressed, and this was reflected in the detailed action plans.

Implementation of some of the strategies is already underway. From 2011 through 2015, implementation will continue, results will be monitored and evaluated, and adjustments will be made as needed to address the health needs of Kansas women, infants, and children.

Title V MCH Block Grant needs assessment requirements are addressed either in the Block Grant narrative materials or in the attached needs assessment report. The MCH2015 needs assessment report was written for dissemination to a larger stakeholder audience. Here is a summary of where needs assessment sections described in the Block Grant guidance are addressed within Kansas' MCH2015 report:

- Section 1 "Process for Conducting Needs Assessment" is covered in Part I of the MCH 2015 report.
- Section 2 "Partnership Building and Collaboration Efforts" related to general Kansas Title V efforts is discussed in detail throughout the Block Grant submission. Stakeholder involvement, partnership building, and collaboration efforts related to the needs assessment is discussed within Part I (Process) and Part IV (Action Plan) of the MCH 2015 report.
- Section 3 "Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes" is presented in Part II of the needs assessment report, and is addressed in detail throughout the Block Grant submission.
- Section 4 "MCH Program Capacity by Pyramid Level". The pyramid was considered by staff throughout the assessment and during action plan/logic model development. However, based on experiences in previous five-year needs assessments, the pyramid and CAST-5 were not utilized as key tools with stakeholders during MCH2015. Rather, capacity issues were addressed through MCH 2015 logic model and work plan development, which is addressed in Parts I (Process) and IV (Action Plan) of the report. Additionally, MCH Program Capacity by Pyramid Level is discussed throughout the Block Grant submission.
- Section 5 "Selection of State Priority Needs" is discussed in Part III (Priorities) of the needs assessment report.
- Section 6 "Outcome Measures -- Federal and State". Kansas did not select additional outcome measures. However, outcomes and their relation to performance measures and priorities are addressed in Parts III (Priorities) and IV (Action Plan) of the report, as well as elsewhere in the Block Grant submission.

III. State Overview

A. Overview

This section puts into context the MCH Title V program within the State's health care delivery environment. It briefly outlines Kansas' geography, demography, population changes, and economic considerations. The overview provides an understanding of the State Health Agency's current priorities/initiatives and the Title V role in these. It includes a description of the process used by the Title V administrator to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the State including current and emergent issues and how these are taken into consideration.

Geography/Demography

Located in the central plains region of the United States, Kansas encompasses 81,815 square miles or about 2% of the land area of the U.S. It is bordered on the north by Nebraska, on the south by Oklahoma, on the east by Missouri, and on the west by Colorado. The topography of the state changes from hills and wooded areas in the east to flat, treeless high plains in the west.

Population Density/Distribution

There were 34.2 persons per square mile in the state in 2008 compared to 86.0 for the U.S. Five cities in the state, all located in the eastern half, have populations that exceed 100,000, including Wichita (366,046), Overland Park (171,231), Kansas City, 142,562), Topeka (123,446), and Olathe (119,993). In 2008, 35 of 105 counties in Kansas had population densities of less than 6.0 persons per square mile. These are located mostly in the western part of the state. The most sparsely populated county was Wallace along the Colorado border with a density of 1.5 persons per square mile. The most densely populated county was Johnson with 1,119.7 persons per square mile. This county is on the eastern border of the State.

Urban/Rural

Most of the population growth over the past decade occurred in the eastern portion of the state, where the majority of the population lives. While there are many rural areas in eastern Kansas, particularly in southeastern Kansas (Kansas Ozarks), the most rural counties are located in western Kansas. Rural county residents tend to have lower median household incomes, higher poverty rates, and higher unemployment rates.

Population Growth/Change

The 2008 population estimate for Kansas was 2,802,134 or about 1% of the U.S. population (U.S. Census Bureau). Percent growth for Kansas' population from 2000-2008 was lower than for the U.S. 4.2% compared to 8.0%. For younger age groups, however, the population growth rate was slightly higher for Kansas than for the U.S. For children under age 5, the growth rate was 7.2% for Kansas compared with 6.9% for the U.S. For children under age 18, Kansas' population growth was 25% versus 24.3% for the U.S. Women comprise 50.3% of the population roughly comparable to the U.S.

Age

Kansas' population is aging but at a slower pace than the rest of the U.S Median age is 36.2 years which is only slightly younger than the national median age of 36.8. Since 2002, Kansas' population of school age children has decreased 2.5 percent while the older cohorts have steadily increased. The school age population (age 5-17 years) is expected to remain stable through 2010 and then gradually increase.

The under age 5 cohort was unchanged from 2002 to 2005. Since 2005, it has steadily increased. Proportionally, this cohort represents 7.2 percent of the total state population, up 3.3 percent from 2007 to 2008. In 2008, there were 41,815 resident births in Kansas.

Women of reproductive age (15-44) accounted for 19.8%, or 553,481 of the estimated 2.8 million people in the State. There were about 57,321 women ages 15 to17.

Twenty eight percent (28%), or 788,500, of the State's population were children age 19 and younger. In 2008, there were an estimated 521,400 children and adolescents aged 5 to 17.

Race/Ethnicity

White persons comprise a higher proportion of Kansas' population (88.7%) than the proportion for the U.S. (79.8%), There is a lower proportion (6.2%) of Black persons in Kansas compared to the proportion for the U.S. (12.8%). American Indian and Alaskan Native persons are 1.0% for both Kansas and the U.S. Asian persons comprise 2.2% of Kansas' population, but 4.5% of the U.S. population. The proportions for those reporting two or more races are roughly comparable for KS and for the U.S., 1.8% and 1.7% respectively.

The proportion of persons reporting Hispanic origin is only 9.1% for Kansas compared to 15.4% for the U.S.

Diversity/Languages

Kansas' population is fairly homogenous. Only five percent (5%) of Kansas' population is foreign born compared with 11.1% for the U.S. Percent homes in which languages other than English are spoken is only 8.7% compared with 17.9% for the U.S. Refugee health program data for 2009 are representative of about half the annual recent arrivals to Kansas. Of approximately 500 foreign born immigrants in 2009, 21% spoke Nepalese, 18% Burmese,16% Karen, 11% Arabic, and the remaining 34% Chinese, Dari, Farsi, Kayaw, Kurdish, Kunama, Laotian, Somali, and Vietnamese. Refugees located mostly in about five counties in the state: Wyandotte (KC), Sedgwick (Wichita), Johnson, Finney, and Douglas.

Education

Kansas compares favorably with the U.S. average in terms of educational attainment with an 86.0% high school graduation rate compared with 80.4% for the U.S. Twenty five percent (25.8%) of Kansans have a bachelor's degree or higher compared with 24.4% for the U.S.

Income/Poverty

The median household income for Kansas in 2008 was $50,174 compared to $52,029 for the U.S. Per capita income for Kansas was $20,506 compared with $21,587 for the U.S. Proportionately fewer Kansans live below the federal poverty level, 11.3% compared with 13.2% for the U.S. See attachment for distribution of number of children in poverty by county and distribution of percent children in poverty by county.

Economy

The Kansas economy entered a significant downturn in 2009 following the U.S. and global economic downturns. There was a slow period of employment growth through most of 2008, followed by significant job losses in manufacturing during 2009, especially in Wichita's aircraft manufacturing industry. Unemployment for the first 3 months of 2010 was 7.2, 6.8, and 6.9 percent, these compare unfavorably with rates in late 2008 that were approaching 4 percent. http://klic.dol.ks.gov Consumer spending slowed considerably as did State revenues. For the state fiscal year starting July 1, 2010 state legislators faced a projected budget shortfall for the

3rd year in a row. The projected shortfall was estimated at $500 million.

Health Insurance Coverage

In 2007-2008, 12.4 percent of Kansans were uninsured, not statistically different from either the 12.5 percent who were uninsured in 2006-2007 or the 11.3 percent in 2005-2006, but greater than the 10.5 percent who were uninsured in 2004-2005. The percentage of Kansas children (under 19) without health insurance in 2007-2008 was approximately 9.6 percent, up from 7.8 percent in 2006-2007 and 7 percent in 2005-2006. The percentage of Kansans without health insurance in 2007-2008 (12.4 percent) was lower than 15.3 percent for the U.S. Approximately 338,000 Kansans were without health insurance in 2007-2008. Based on 2006-2008 three-year averages, the Kansas uninsured rate was higher than 13 other states and lower than 26 other states. See attachment for percent of children that were uninsured by county for 2006.

Counties with high percent uninsured children per county are clustered in the southwestern part of the state, a largely Hispanic populated area and presumably many are not Medicaid or SCHIP eligible. The southeastern portion of the state (Kansas Ozarks), on the other hand, has a cluster of counties with large number/percent of children in poverty but the children are less likely to be uninsured than those in the southwestern part of the state.

Health Care Delivery Environment

Primary Care Access/Workforce

The most prominent barrier to care in Kansas is lack of financial access as measured by income and uninsurance rates. Although the most recently available data for the uninsured rate in Kansas, the U.S. Census Bureau's March 2008 Current Population Survey, is from before the current economic recession, it found that approximately 340,000 Kansans were uninsured in 2006-2007, up from 307,000 in 2005-2006. Of these, 61.4% were considered low-income (household incomes at or below 200% of the federal poverty level) and likely unable to afford the cost of health insurance premiums or the full cost of personal health care services when needed. Kansas was one of 10 states that showed an increase in its uninsured rate during this period. Kansas moved from 11th to 20th among states with lowest uninsurance rates. Kansans with insurance still had access issues due to the lack of primary care providers throughout the state.

Currently, Kansas has 84 federally-designated, primary care Health Professional Shortage Areas (HPSAs). These include entire counties, cities, or areas with underserved populations. Of the current primary care HPSAs, 28 are geographic HPSAs and 56 are population HPSAs, indicating both geographic and financial access problems among residents across the state. Only twelve of Kansas' 105 counties do not have a primary care HPSA within their borders. Only five others have primary care HPSAs that only make up a portion of their counties. In the remaining 88 counties, the entire county is federally designated as a Health Professional Shortage Area.

The state of Kansas has shown a commitment to funding the provision of medical services in underserved areas. In 1992, beginning with $800,000 in state funding for nine primary care medical projects targeted to uninsured and other underserved populations, the program has grown substantially, especially within the last four years. Current funding for state fiscal year 2010 is $7.48 million dollars in funding to 38 clinics around the state with sites in 31 Kansas counties. There has also been a rapid expansion in Federally Qualified Health Centers (FQHCs) in Kansas over the last few years, from 7 in 2000 to 15 FQHCs and one FQHC look-alike in 2010. The expansion of access to primary care services is a major achievement in the state but often the inability to find needed providers by these clinics has hindered their ability to provide primary care services at full capacity.

A number of reports are generated annually by state programs and other entities on primary care access. Among these are the "Primary Care Access Report" the "Annual Report of the

Statewide Farmworker Health Program" Special studies focus on workforce issues such as the aging of the workforce study -- www.kdheks.gov/ches/download/AgingPhysician2009.pdf

The state agency in partnership with the Dental Association and numerous other organizations has completed workforce analyses resulting in policy initiatives on dental workforce.

Public Health System

Kansas has 105 counties and just fewer than 300 school districts. Almost every county has a local health department (99 counties) and every county has some type of public health 'presence.' Many school districts utilize contracts with local public health nurses for school nursing services, particularly in the smaller counties. In order to meet national public health accreditation standards, many of the smaller county health departments have considered organizing as regional public health entities. Importantly, local health departments are not state operated. Rather, they are units of local and county government and operate autonomously of the State health department.

There is a strong partnership between the State and local public health departments that is manifest in collaborative activities such program planning and policy development. The Kansas Public Health Association provides a forum for many of these activities and the Kansas Association of Local Health Departments coordinates communications among local health departments and between the State health agency and local agency council. As well, there are many other joint conferences and events that serve to bring together state and local public health workers.

There are four very active health foundations in the state that are major drivers of public health policy. These include the Kansas Health Foundation, Sunflower Foundation, United Methodist Health Ministries, and Kansas City's REACH Foundation. The State has a very active public health-focused research institute, the Kansas Health Institute. It is a source of much public health information and analysis for policy making. The institute convenes legislators and public health staff in forums to consider policy options and these no doubt serve to inform public policy. Beginning in Fall 2009, the KHI initiated a series called "Children's Health in All Policies" convening MCH staff, legislators and others. This contributed to the many positive outcomes in the 2010 session such s reinstatement of funding for teen pregnancy prevention, protection of funding for social services, education, early childhood, and Medicaid.

State funding of public health is largely targeted towards specific activities and programs, unlike some other states that have large amounts of funding portioned out to counties on a per capita basis for core public health activities. This is not to say that there is no per capita funding, but the 75 cents per capita funding provided through the "State Formula Fund" is a very small portion of the overall state funding for local public health activities in the state.

Public Health Insurance

Previously located in the state social services agency, Kansas' Medicaid agency was relocated to the Kansas Health Policy Authority, a separate state agency, in 2005. The Authority is responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. All health insurance purchasing by the State is now combined under the Authority including publicly funded programs (Medicaid, State Children's Health Insurance Program, and Medikan) and the State Employee Health Benefits Plan (SEHBP). The Authority is responsible for compiling and distributing uniform health care data in order to provide health care consumers, payers, providers and policy makers with information regarding trends in the use and cost of health care for improved decision making. The KHPA is governed by a nine-member board, including health care, business, and community leaders appointed by the Governor and the Legislature, as well as eight ex-officio members that include State Cabinet Secretaries and the Executive Director of KHPA.

The interface between Title V MCH and Title XIX Medicaid is documented in the KHPA/KDHE Interagency Agreement. The document is updated at regular intervals to clarify roles and responsibilities and the most recent update of this document is dated September, 2009. KHPA staffs participate in Title V activities such as the MCH Advisory Committee and they advise on matters pertinent to both agencies.

State Health Agency Current Priorities and Initiatives

The state health agency's current priorities and initiatives were apparent in the initiatives introduced and shepherded through the 2010 legislative session: clean air act (smoking ban in public places); expansion of child care licensing inspections to registered family day care homes (the so-called Lexie's Law - health and safety while in out-of-home care); changes to the Vital Statistics statutes to allow use of birth certificates for maternal surveillance purposes such as PRAMS and FIMR; maintenance of dedicated use of tobacco settlement funds for programs serving children ages birth through five (including MCH home visiting, Infant Toddler Services, and Newborn Screening); primary seat belt law, requirement for Kansas colleges to have a plan for controlling tuberculosis on campuses; opt-out for HIV infection screening of pregnant women; audiologist licensure requirement of doctorate or equivalent; certification of radon technicians; prohibition of texting while driving.

Obesity reduction measures such as school vending, menu labeling, and tax on sugar sweetened beverages did not pass despite considerable public approval for these measures. Likewise, increased taxes on cigarettes and other tobacco products did not pass. It is anticipated that obesity and tobacco use reduction measures will move forward into the next legislative session. The state school board has moved on the school vending machine proposal.

The state health agency focus is on prevention/wellness, social determinants of health, life course perspective, and health equity. The agency has established a bureau of environmental health encompassing Environmental Public Health Tracking, lead screening and abatement, radon and radiation protection and control, among others. There has been renewed focus on reducing racial and ethnic health disparities with the office of minority health taking a larger role and the establishment of the Blue Ribbon Panel on Infant Mortality.

Title V MCH Roles and Responsibilities in Agency Initiatives

The mission statement for the Bureau of Family Health embodies its roles and responsibilities both outside and within the agency: to provide leadership to enhance the health of Kansas women and children in partnership with families and communities. While other bureaus in the division of health have initiatives relating to the health of women and children, none has as its exclusive mission the health and wellbeing of women and children.

A major focus of all the policy and program initiatives is partnership. There is stakeholder involvement in all Title V activities that includes both providers and consumers. Title V MCH is a leader in the agency in drawing on key players to help them play important roles in shaping the future of the state. Through existing forums, Title V has engaged stakeholders in advocacy for improving the health status of women and children. Title V has provided or assisted in project management for special groups such as the Governor's Child Health Advisory Committee, Early Learning Coordinating Council, State Genetics Plan Stakeholders, Newborn Screening Advisory Council, Families Together, the Blue Ribbon Panel on Infant Mortality, and the emergent Kansas Breastfeeding Coalition. Title V has provided staffing and resources support to other emergent issues including H1N1, bioterrorism coordinating council, Developmental Disabilities Council, Autism Task Force, Food Security Task Force, Health Department Accreditation, and Healthy Kansas 2020. The Kansas MCH Coalition (a merger of the Kansas Perinatal Council and the Kansas AAP Advisory Group) has served as a forum for policy and priority issues relating to the health of Kansas mothers and children.

A good example of partnership activities during the past year is the ABCD+ initiative. This initiative focuses on behavioral and mental health screening and treatment. Survey data of healthcare providers on the issues of mental health diagnosis and treatment for children and adolescents revealed pediatric providers are uncomfortable diagnosing and managing mental health disorders even common ones such as depression and anxiety. It was also apparent that an overwhelming majority of providers experienced a lack of resources. Finally, most primary care physicians were willing to provide these services if given adequate training and resources

The Kansas Chapter, American Academy of Pediatrics (KAAP) and the KDHE MCH staff convened a multi-agency task force to increase the number of children (ages 0-18) that receive mental health screening and appropriate mental health referral and treatment. Other agencies involved included: Kansas Health Policy Authority (KHPA) - Medicaid; Kansas Department of Social and Rehabilitation Services (SRS) - mental health and substance abuse designated agency and Kansas Health Solutions provider network; Association of Community Mental Health Centers of Kansas (ACMHCK) Community Mental Health Centers in Kansas; Private Mental Health Consultant of the Governor's Children's Mental Health Council; Kansas Behavioral Science Regulatory Board (KBSRB); Kansas Health Institute (KHI); and the Kansas Academy of Family Physicians (KAFP). The task force is patterned after the Assuring Better Child Health and Development (ABCD) project, a quality improvement initiative in primary care practice to improve developmental screening. .

The project developed a three-pronged approach. First, develop an easily accessible web-based resource list -- KidLink Resource Directory -- with contact information including a stratified level of care of all Kansas public and private mental health providers and therapists that serve the pediatric population. Second, develop and deliver education to healthcare providers in the use of evidence-based screening tools and appropriate early intervention resources to increase their competence level in diagnosis and treatment of childhood developmental and mental health disorders. Third, teach healthcare providers to navigate the KidLink Resource Directory of mental health providers in their geographical regions in Kansas with the ultimate goal to get children and adolescents into treatment interventions as soon as possible. Regional networking and collaboration between primary care providers, child/adolescent psychiatrists, and other mental health providers is essential to improving mental health in children.

Another example of work across agencies is the State Child Death Review Board (SCDRB). MCH represents the Kansas Department of Health and Environment on this board. The SCDRB was created by the Kansas Legislature in 1992 and is administered by the Kansas Attorney General's Office. The SCDRB ten-member multi-disciplinary panel whose appointments are defined by statute are comprised of medical, law and social service professionals. The purpose of the SCDRB is to "determine the number of Kansas children who die annually, describe trends and patterns of child deaths, identify risk factors . . . [and] develop prevention strategies in order to lower the number of child deaths."

A third example of partnership is school nursing services. MCH is responsible for guidance to local school district nurses. The 2010 Guidelines for Medication Administration in Kansas Schools is a revision of the 2001 guidelines providing guidance and resources for school personnel responsible for children with acute and chronic illnesses requiring medication during the school day. School districts must meet this need in the interest of facilitating school attendance and compliance with applicable state and federal laws, establishing policies and implementing procedures that meet all legal requirements for administration of medication required during school hours. Medication administration procedures must be consistent with standards of medical, nursing, and pharmacy practice guidelines. The revised expanded guidelines include sample forms, supporting documents, and links to resources and information facilitating safe and timely medication administration in the school setting.

Beginning in May of 2009, the Kansas MCH program was an integral partner in the agency

response to pandemic influenza. Nursing and epidemiology staff assumed additional responsibilities serving on the H1N1 Phone Bank assisting with calls from health providers and the general public, development of resource materials posted on the Kansas Department of Health and Environment (KDHE) Web site, and education of MCH staff in the local agencies. Other staff worked with the Center for Public Health Preparedness (CPHP) deploying supplies from stockpile warehouses out to Kansas providers. MCH served on the KDHE Community Mitigation Team. This team was charged with assisting with weekly statewide telephone conference calls with local health departments and providers and development of educational and resource materials.

The current public health leadership within the agency has pursued a course of greater public awareness of the importance of public health to the overall health of the population, the important roles and responsibilities of the state public health agency in achieving and maintaining a healthy population. The achievements in the 2010 legislative session are a testament to the positive impact of this approach with policy makers and the public. Whereas previously the focus was on insurance status and access to care, there has been a shift in public opinion to the merits of public health strategies.

In summary, the MCH role within the state Title V agency is to provide leadership to issues and concerns at the state and local levels affecting the health and wellbeing of Kansas mothers and children. This is manifest in many program and policy initiatives that are described here and elsewhere in this application. Overlaying all these initiatives and challenging many of our efforts, is the state's budget situation. The budget will remain the most significant issue for the state and for MCH in the foreseeable future. At the same time that budget pressures threaten program services, there is increased demand for services and supports by families impacted by the economic recession. Revenues remain unstable at both the state and local levels.

In addition, there are anticipated changes. Health care reform is slowly changing the face of the service system. A change in leadership in state government is expected during the coming year and along with this change, priorities and policy shifts may be expected. The agency including MCH is developing a public health agenda with these changes in mind. .

References:
1) Kansas Quick Facts, U.S Census Bureau 4/22/2010
http://quickfacts.census.gov/qfdstates/20000.html
2) Governor's Economic and Demographic Report, 2009-2010, Kansas Division of Budget, January 2010
3) Kansas Health Institute, April 2010 Reports www.khi.org
4) Kansas Annual Summary of Vital Statistics, 2008
5) KDHE Primary Care and Farmworker Health Programs.

An attachment is included in this section.

B. Agency Capacity

This section addresses the capacity of the Kansas Title V Agency to promote and protect the health of all mothers and children, including CYSHCN. It describes Kansas' capacity to provide essential public health services for pregnant women and infants, children and adolescents, and children with special health care needs.

Kansas has established a vision, mission and goals for maternal and child health through a strategic planning process. Capacity assessment is included in the 5-Year MCH State Needs

Assessment, MCH 2015. Through this process, Kansas has identified the priority health issues and desired population health outcomes for mothers and children. A review of the political, economic, and organizational environments for addressing the priority health issues is included in the MCH Services Block Grant application that accompanies the needs assessment. All relevant information is utilized to set strategic directions for the Title V program in terms of identification and implementation of organizational strategies to achieve the desired outcomes for the maternal and child health population.

Also, Kansas uses the ten essential public health services to guide decision-making in all aspects of program operation. For the five year needs assessment, essential services were used as the basis of building logic models and work plans to address priority needs through 2015. Following is an overview of Kansas' Title V capacity in relation to each of the ten essential maternal and child health services.

Essential Service #1. Assess and monitor maternal and child health status to identify and address problems. Kansas uses public health data sets to prepare basic descriptive analyses related to priority health issues. Data from the Prenatal Nutrition Surveillance System (PNSS) and the Pediatric Nutrition Surveillance System (PedNSS) are available through the WIC program database. Data from the Behavior Risk Factor Surveillance System (BRFSS) is readily available and MCH has an opportunity each year to support additional modules on emergent issues in MCH/CYSHCN. Oral health and women's health modules have been funded in recent years. The Youth Risk Behavior Survey (YRBS) is conducted each year by the state department of education in partnership with local school districts. Previously, the data were not considered representative of the youth population due to non-participation of some school districts. Now, through the auspices of the CDC Coordinated School Health Program, the data are representative and useful to the Title V program in tracking youth health behaviors.

Vital statistics data of high quality are available to Title V through an approval process. Since 2005 hospitals submit records electronically to the state agency via a web-based system. The system implements the new NCHS standards. In 2007, MCH first received data from the new system. Any analysis of trend data now takes into consideration the timeframe for conversion to the new system. Entry into prenatal care, adequacy of prenatal care and birth defects reporting are some of the variables that were affected by the conversion. The new system expands the amount of data available and improves the ability of Title V to assess birth/death and birth risk data.

Changes to the Vital Statistics statutes during the 2010 session allow use of the system to survey recent mothers for purposes of maternal health surveillance. MCH is identifying resources to conduct Prenatal Risk Assessment Monitoring System (PRAMS). Local agencies have identified resources to conduct Fetal Infant Mortality Review (FIMR) at the community level.

Other data sets maintained by other bureaus within the department that are used for various analyses include: immunization, cancer registry, child care licensing, STDs, HIV, State laboratory, primary care, farm worker health, trauma registry, as well as BFH program services data systems (WIC, MCH, CYSHCN, Part C, Family Planning, Newborn Screening, Newborn Hearing Screening). Use of these data sets is outlined in relevant sections of this application.

Title V has access to data sets outside the state agency such as Medicaid data (MMIS & Clearinghouse), hospital discharge data, department of transportation data (motor vehicle accidents), Kansas Bureau of Investigation (intentional injuries), department of social services, education department (school lunch program, school injuries). The annual MCH Block Grant application includes a good representative sample of the types of data in use. The State Systems Development Initiative (SSDI) grant provides a good overview of data quality and data linkage capacity.

BFH has two epidemiology positions. Additional epidemiological support would be beneficial.

The epi's serve as data analysts and resource persons for: Kansas' five year needs assessment, KDHE Healthy Kansans 2020, analysis of the National CYSHCN Survey, National Child Health Survey, birth defects data, and numerous ad hoc projects throughout the year. There is not sufficient capacity to conduct analyses of MCH data sets that go beyond descriptive statistics, although there has been some work in this area. BFH epidemiologists and other staff have compared health status measures across populations. The TVIS on the MCHB website is used often as a means of comparing health status measures for Kansas with those of other States.

The State has very limited capacity to generate and analyze primary data to address State and local knowledge gaps although there is some work in this area to generate CYSHCN data -- medical home, youth transition, and financial access. Information is needed beyond that available from the National CYSHCN Survey. Annual surveys are conducted to assess school nursing capacity. WIC conducts periodic family surveys. CYSHCN conducts regular surveys of family satisfaction with services.

Primary and secondary data are analyzed routinely and used in policy and program development across all BFH programs but the quality and consistency of the analyses varies based on staffing and other considerations. MCH grants to local agencies require local needs assessment to determine local priorities although capacity to provide training and technical assistance to the local agencies relating to the priorities is limited. Local agency epidemiological capacity ranges from highly sophisticated, primarily in urban areas, to very unsophisticated. Training of local staff to achieve some level of competence in use of data is ongoing. Training of State agency staff to achieve some basic level of competence across all BFH programs is ongoing as well. For the epidemiologists, specialized epidemiological training has been identified and completed. One such example is epidemiologist training in genetic epidemiology through the Sarah Lawrence College Public Health Genetics/Genomics certificate program.

Essential Service #2. Diagnose and investigate health problems and health hazards affecting women, children, and youth. BFH uses epidemiologic methods to respond to MCH issues and sentinel events. The Title V program engages in collaborative investigations and monitoring of environmental hazards (e.g., State schools for the deaf and blind, juvenile correction facilities, birthing centers) to identify threats to maternal and child health. The MCH epidemiologists participate in cross-bureau activities such as development of policies and procedures for cluster investigations to be observed by all programs.

The Title V program has been unsuccessful in applications to CDC for birth defects surveillance so the Title V program utilizes MCH Block Grant funds for some limited activities in this area. The Title V program continues to pursue federal funds to implement a law passed in the 2004 session giving the State agency statutory authority for birth defects surveillance. A formal request has been sent to CDC requesting on-site technical assistance to assess current efforts and to develop a plan and budget for future development efforts.

During the 2010 session, statutory authority to utilize birth certificate data to survey recent mothers was obtained largely through the efforts of the Blue Ribbon Panel on Infant Mortality. This legislation opens the way for Prenatal Risk Assessment Monitoring System (PRAMS) and Fetal-Infant Mortality Review (FIMR) efforts in the state. Increasingly, the MCH epidemiologists serve as the State's expert resource for interpretation of data related to MCH issues. The Title V program is regularly consulted on MCH data issues and staffs participate as experts in planning processes. The agency provides leadership for reviews of fetal, infant, child, and maternal deaths through its work with the Kansas Perinatal Council. Title V serves on the state Child Death Review Board and serves as interface in information sharing for implementing community-based interventions. Through the MCH needs assessment process, Title V uses epidemiologic methods to forecast emerging MCH/CYSHCN threats that can be addressed through planning processes.

Essential Service #3. Inform and educate the public and families about maternal and child health issues. Title V has no health education plan per se and no dedicated health educators. These

functions are incorporated into the job duties of all Title V staff. There is no dedicated funding for health education activities, such as for print or media campaigns, although this may change with new priorities of MCH 2015. The CYSHCN program incorporates information and education to the public and to families about medical home, transition and other at specialty clinics as a routine part of its activities. Grants to local agencies and organizations encourage health education activities at the local level with the new focus on prevention/wellness, social determinants, life course perspective and health equity.

Title V engages in population based health information services, providing health information to broad audiences. Title V collaborated with Kansas Action for Children on a statewide media campaign to raise public awareness about the importance of oral health for pregnant women and children. MCH partnered with the March of Dimes on a public health education campaign on the importance of folic acid and also on prematurity. Title V partnered with early childhood programs on dissemination of information about text4baby, with WIC services on breastfeeding promotion. CYSHCN has expanded information resources available to families through the toll-free number and website.

The public information office of KDHE has new capacity and assists programs with public information through news releases, press events, print material development, website development, response to news reporters and related services.

Essential Service #4. Mobilize community partnerships with policy makers, health care providers, families, the general public, and others to identify and solve maternal and child health problems. The Kansas Title V program is strong in this area, responding to community MCH concerns as they arise, regularly communicating with community organizations. Needs assessments and planning activities engage community audiences on state and local needs. The Title V program supports the office of health care information to produce issue- and population-specific reports that are distributed widely in the state. Informal mechanisms are utilized to obtain input into the Title V program on MCH/CYSHCN needs.

The 5-year state needs assessment process is a formal mechanism for obtaining community input into the program. Funding and technical assistance are provided to local providers for services that are determined locally through a community needs assessment process. No additional funding is available for local programs to establish community advisory boards but grants to local health departments and other community organizations encourage liaison with city and county policy makers, school officials, and other local groups. Kansas Title V supports coalition and stakeholder groups primarily through technical assistance, although as in the case of the State Early Childhood Comprehensive Systems (SECCS) grant, funding may also be provided for planning activities. For the implementation phase of SECCS, Title V has maintained both supportive and leadership roles. The SAMHSA LAUNCH initiative builds a local coalition in the Finney county area with a focus on early childhood systems.

Title V has been assigned responsibility for coordinating the Governor's Child Health Advisory Committee (CHAC) charged with developing recommendations relating to immunizations, newborn screening expansion, school health education, and physical fitness/nutrition. The President of the Kansas Chapter of the AAP, heads the group of 18 appointees. CHAC recommendations to the KDHE Secretary translate to policy and program initiatives.

Essential Service #5. Provide leadership for priority setting, planning, and policy development to support community efforts to assure the health of women, children, youth, and their families. Title V assembled a Panel of Experts for the state needs assessment, MCH 2015. Title V plays a major role in development and implementation of the State Early Childhood Comprehensive Systems strategic plan, Bioterrorism planning, Continuity of Operations Planning, H1N1 planning, and planning for the Healthy Kansas 2020 process to determine priorities for the State agency. MCH/CYSHCN routinely lead and/or participate in data-driven decision making and planning activities. The annual and five-year Title V grant application and needs assessment cycle

assures a systematic review of progress on objectives. Title V actively promotes the use of scientific knowledge bases in the development, evaluation, and allocation of resources for policies, services, and programs. A project underway for the MCH epidemiologists is production of the MCH Biennial Summary. The national and state performance measures serve as the basis for this report.

In 2009, the Secretary of KDHE convened a Blue Ribbon Panel on Infant Mortality to make recommendations on reducing Kansas' high infant mortality rate (2004-2006 MMWR Vo. 58, Number 17). Title V facilitated this effort. The Panel adopted a set of preliminary recommendations and agenda for the 2010 legislative session. Multiple organizations including March of Dimes and Kansas Action for Children advocated for these measures. The result was passage of amendments to the vital statistics statutes removing barriers to the use of birth certificates for MCH surveillance. Effective July 1, 2010, PRAMS or PRAMS-like surveys of recently delivered women will commence. The law will also facilitate access to data for FIMR projects in Kansas City and Wichita.

Formal advisory structures advise and assist KDHE on MCH/CYSHCN issues: the Kansas MCH Council, the CYSHCN Council, the Integrated Community Systems for CYSHCN grant council. Parents from Families Together, Kansas' version of Family Voices, participate. MCH/CYSHCN facilitates meetings of these groups throughout the year and solicits input on major issues impacting the health of mothers and children. MCH epidemiologists are available to support the deliberations of the groups.

Other groups convened are the Newborn Screening Advisory Council, the Sound Beginnings Advisory Council (newborn hearing screening), Genetics State Plan group, Nutrition and WIC Advisory Committee, Interagency Coordinating Council for special needs infants and toddlers, and the Family Planning Advisory Committee. Generally groups meet on a quarterly or as needed basis.

Kansas Title V regularly utilizes data available within the department as well as data from other agencies and organizations (state, local and/or national) to inform State MCH health objectives and planning. Recently, early childhood organizations requested MCH epidemiological support in developing the needs assessment for the Kansas application for federal home visiting funds. The annual MCH Block Grant utilizes a systematic process to produce an overview of the health of all mothers and children in the State.

Title V staffs are involved in multiple State-level advisory councils: Governor's Commission on Autism, Kansas Commission on Disability Concerns, Head Start, Kan-be-Healthy, Traumatic Brain Injury, Assistive Technology, and State Hunger Task Force. Routinely, staff partner with other agencies and programs listed in the collaboration section of this application. Title V has a number of formal interagency agreements for collaborative roles such as the agreement for the Individuals with Disabilities Education Act (IDEA) programs of Part C (located in the State health agency) and Part B (located in the State education agency); agreement with the Interagency Coordinating Council, agreement with KU's poison control center to assist in national certification efforts, KHPA/KDHE interagency agreement primarily focusing on Medicaid and SCHIP.

Title V has contributed to the planning processes of several State initiatives. Routinely, Title V staff are consulted by others needing guidance on MCH population services. Over time there has been a pattern of a gradual shift towards other programs developing independent capacity to address traditional MCH issues. Two examples of this shift are: hiring of a staff person within the Bioterrorism program to address MCH issues and development of programs to address needs of school aged population by chronic disease through the CDC Coordinated School Health grant. Still, Title V serves as the representative of the State health agency at key meetings such as public/legislative hearings relating to MCH/CYSHCN issues.

Essential Service #6. Promote and enforce legal requirements that protect the health and safety

of women, children, and youth, and ensure public accountability for their well-being. Title V has not coordinated a formal review of legislative and regulatory adequacy and consistency across all programs serving MCH populations for many years. Instead, there have been a number of reviews of specific legislation or regulations due to emergent policy or program issues.

Title V participated with child care licensing and the Kansas Perinatal Council in a review of outdated birthing center regulations. The group recommended that the State adopt national standards for birthing centers. The regulations have been finalized and are soon to be adopted. This year, newborn screening and birth defects reporting regulations were amended to account for the expansion of newborn screening testing.

Title V staff routinely provide oral and written briefings to policy makers on maternal and child health issues. Examples of these activities include testimony in legislative hearings, issue papers, and briefs. Subject matter may be on a wide range of issues and advisory committee members from university and clinical areas may be called on to participate.

As part of the KDHE budget process, MCH puts forward proposals for legislation, budgetary or regulatory changes each summer. In late summer, proposals are reviewed by an internal executive team and selected as priorities for the State agency. These are incorporated into the budget that is submitted to the Governor in early Fall. A new development for 2010 is a June retreat for directors in the division of health that will be used to select key priorities for the 2011 session.

Title V staff are encouraged to participate in professional organizations and to engage with other State agencies in the development of licensure/certification processes. Title V provides leadership to the development of quality standards of care for women, infants and children in collaboration with other agencies and organizations such as Medicaid's EPSDT Advisory Board, Hearing Screening Guidelines and Vision Screening Guidelines, birthing center regulations. Specialty clinic standards are another standard setting activity. The Title V program has collaborated with Medicaid and SCHIP to incorporate MCH standards and outcomes such as the low birth weight Pregnancy Improvement Project with First Guard, adoption of the CYSHCN definition in managed care contracts, and use of the CYSHCN program for consultation regarding care. MCH promotes Bright Futures as the standard for local MCH agencies throughout the State. MCH/CYSHCN staffs have been involved in policy and legislative initiatives for child passenger safety seats, child care health consultation, regulations relating to community-based and faith-based organizations that serve pregnant women.

MCH conducts on-site reviews of local agencies and allocates staff resources to provide technical assistance. Training and technical assistance are increasingly provided through new technologies such as on-line training (KS-Train) and Go to Meeting. The MCH aid to local program has initiated a risk-based schedule for reviews of local agencies to improve efficiency.

Essential Service #7. Link women, children and youth to health and other community and family services and assure quality systems of care. The Kansas Title V program develops, publicizes and routinely updates its Make a Difference Information Network (MADIN) toll-free line. The program uses the State language assistance contract to obtain interpretation services as well as Spanish-speaking staff. There are plans to use print materials, website and other means to publicize the line. At all points of contact with women, children, and families the Title V program provides verbal information and/or print materials about publicly funded health services. The Title V program assists localities in developing and disseminating information and promoting awareness about local health services through such activities as community resource and referral lists that are maintained at each local service site. There has been no systematic effort to evaluate the effectiveness and appropriateness of efforts to link women and children with services.

Kansas Title V coordinates with managed care organizations (MCOs) on outreach and home

visiting services for hard to reach populations. Innovative methods of providing services such as one stop shopping in Wyandotte County and CYSHCN involvement in Juniper Gardens have been encouraged although there has been no funding for these efforts. Technical assistance is provided at conferences and during on-site visits to local agencies, also to providers in identifying and serving hard-to-reach populations. BFH disseminates information on best practices to local agencies, providers, and health plans across the State.

Tracking systems for universal, high risk and underserved populations have been utilized for newborn metabolic screening and newborn hearing screening follow-up. There has been some use of the birth defects statutes that permit program information and brochures to be mailed to parents of children with high risk conditions noted on the birth certificate.

MCH and CYSHCN link families with services. Partial support for direct services is provided only when not otherwise available. Examples of these services are: child health assessments for school entry through local health departments for uninsured and underinsured children and CYSHCN medical specialty clinic services.

Resources are provided to strengthen the cultural and linguistic competence of providers and to enhance their accessibility and effectiveness. CYSHCN and other staff routinely authorize interpreters at out-patient appointments for families who have English as a second language and also for those who phone for assistance. Interpretation services are available within KDHE through the public information office and the farm worker health program. All staff participate in cultural competency training as well as continuing education opportunities as these are available. The Title V program assures that local health departments and other local agencies interface with culturally representative community groups and prepare outreach materials and media messages targeted to specific groups. When there are vacant positions, there has been an effort within MCH to recruit persons of color and bilingual staff in partnership with Human Resources.

Despite a number of challenges to MCH-Medicaid collaboration due to organization changes, the staffs of Medicaid and MCH continue a close working relationship. The update of the KHPA/KDHE Interagency Agreement (Title V/Title XIX) was finally completed in Fall 2009. Staffs meet with foundations, professional organizations and other potential partners regarding established and new ventures. Interagency agreements are routinely reviewed for effectiveness and appropriateness. Kansas works with the Medicaid agency and its contractors, and public/private providers on enrollment screening procedures, tracking of new enrollee utilization of services, and consumer information.

MCH/CYSHCN provides leadership and resources for a statewide system of case management and coordination of services by convening community providers and health plan administrators to develop model programs and linkages. The Title V program distributes best practices information through conferences, website, and program-specific training. Kansas provides leadership and oversight for systems of risk-appropriate perinatal and children's care and care for CYSHCN including: cross-agency review teams; developing and monitoring risk-appropriate standards of care; and, routine evaluation of systems.

Essential Service #8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs. A link between the Title V program, the school of public health, and other professional schools to enhance state and local analytic capacity has been established. Internship/practicum students have been utilized. In 2009, a summer intern assisted with development of H1N1 and Pregnancy: FAQs that was posted on the KDHE Web site and utilized in training for Healthy Start Home Visitors during the fall regional training by MCH staff. For 2010, the CYSHCN program will have a summer intern for its Integrated Systems grant.

Academic partnerships, joint appointments, adjunct appointments, and sabbatical placements have been considered but not undertaken. Title V staff occasionally guest lecture at professional

schools in the State such as the school of social welfare and the public health certificate program. MCH/CYSHCN collaborates with the primary care program to monitor changes in the public health workforce. Resource inventories of facilities and programs are also available through this source. Geographic coverage and availability of services and providers are monitored. The 5-year State needs assessment addresses to some extent workforce issues and workforce gaps as these pertain to overall program planning. Examples of activities to address workforce shortages include: Title V coordination with Medicaid, the Kansas School Nurse Organization, the Kansas Association of Local Health Departments, and others to assure statewide fluoride varnish training for nurses. Another example is coordination with Head Start, Early Head Start and other early childhood providers to adopt a quality curriculum for home visitors in the State and assure consistent training for home visitors across all programs.

Kansas MCH/CYSHCN builds the competency of its workforce through support for continuing professional education for staff. All staffs maintain an Individual Professional Development Plan (IPDP). They participate in orientation and training and in ongoing in-service education. Title V staff are encouraged to log on to mchcom.com archived materials to obtain information on emergent issues. Staffs participate in UIC Leadership Conferences, the annual AMCHP meeting, and other in-state and out-of-state education opportunities. In-service meetings are held each month. Topics and speakers are drawn from suggestions of participants. All supervisors collaborate with State human resources office in establishing job competencies and qualifications. If relevant, Title V includes job qualifications in contract requirements with local agencies as, for instance, in requiring multidisciplinary teams for prenatal care coordination services, or nursing/social work for case managers.

Essential Service #9. Evaluate the effectiveness, accessibility and quality of personal health and population-based maternal and child health services. MCH/CYSHCN evaluates outcomes of the services provided. This occurs through outcomes reporting and routine monitoring of all funded services. For some services such as Family Planning and Healthy Start home visiting, patient satisfaction with services is routinely assessed and there is a feedback loop with providers. For others there is submission of qualitative and quantitative data by local projects that is assessed and included in the grant application and the grant review. Some but not all require submission of an evaluation plan. For others such as the SAMHSA LAUNCH grant, a contract is secured with an outside evaluator in academia. Technical assistance may be provided to local agencies to design, analyze, and interpret their data depending on the program. State data is available to local agencies to facilitate implementation of their community assessments and evaluations through Kansas Information for Communities, Kansas Health Institute, and other data sources.

Consumer satisfaction is routinely assessed for all programs. Various mechanisms are used to assess satisfaction including mail-in postcards provided at the time of the service, phone surveys, family advocacy feedback, and focus groups. The Families Together contract includes a requirement for assessment of client satisfaction with services. Title V performs comparative analyses of programs and services when data are available across different populations or service arrangements such as for family planning or WIC. Special satisfaction surveys and focus groups have been conducted with families participating in CYSHCN and attending CYSHCN clinics. As requested, the results of monitoring and evaluation activities are reported to program managers, policy makers, communities and families/consumers. When there are deficiencies, corrective action is taken.

The Title V program disseminates relevant State and national data on "best practices." MCH plans quality improvement activities and communicates these to local agencies and other groups as needed. Information from evaluation and quality improvement activities does not necessarily translate into programs and practices. Interest groups outside the Title V agency are likely to influence program and policy development. Thus, there is a need for stakeholder involvement in all phases of planning, program development, operation, and evaluation.

The Title V program has not identified a core set of indicators for monitoring outcomes of private

providers and is not currently at the table in discussions with insurance agencies, provider plans, and others about the use of MCH outcomes in their own assessment tools. An exception to this is the SECCS plan. MCH is a key partner in development of core indicators for early childhood health.

Essential Service #10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health related problems. The MCH program disseminates ZIPS, a monthly newsletter which abstracts current MCH research and reports to the readership. Staffs engage in research on a very limited basis. Examples of the types of research undertaken this year include an analysis of risk factors for newborn hearing screening loss to follow-up and loss to screening. An ongoing research project is that in partnership with Medicaid using hospital discharge data showing relative health status and health outcomes of women and children covered by public/private insurance plans. When research is undertaken, it is widely disseminated upon completion. MCH and KDHE are highly regarded for the availability of high quality data regarding many diverse health-related issues. Only very limited staffing resources are available for research, for local demonstration projects and special studies. Much of the research work is of a collaborative nature and done in consultation with other individuals inside and outside the agency.

An attachment is included in this section.

C. Organizational Structure

The Secretary of the Kansas Department of Health and Environment (KDHE) is appointed by the Governor and serves on the Governor's Cabinet. The Secretary reports directly to the Governor. Previously four division diectors reported to the Secretary. In 2005, the four divisions were consolidated into two: Health and Environment. Health encompasses vital statistics and Environment now includes the state laboratory. The Director of Health, Jason Eberhart-Phillips, serves as the State Health Officer a position he has held since February of 2009. His background in chronic disease, epidemiology, and local health department management makes him uniquely qualified to serve in this role.

The Division of Health has eleven bureaus: Disease Control and Prevention (infectious disease); Bureau of Environmental Health (lead screening and abatement, radon, environmental tracking); Bureau of Family Health (maternal and child health); Bureau of Child Care Licensing and Health Facilities (child care & hospital regulation, credentialing); Bureau of Local and Rural Health (primary care, farmworker health); Bureau of Health Promotion (chronic disease); Bureau of Oral Health; Bureau of Public Health Preparedness; Bureau of Surveillance and Epidemiology; Bureau of Public Health Informatix; and the Bureau of Minority Health.

The Bureau of Family Health (BFH) administers the $4.7M MCH Services Block Grant. BFH has four sections: Nutrition and WIC Services; Children's Developmental Services, Children and Families Services(MCH); and Children and Youth with Special Health Care Needs (CYSHCN). The organization charts for the agency, the BFH and the four sections are attached as PDF files. Also, refer to the website at www.kdheks.gov/bcyf.

Within the Bureau there are a number of cross-cutting initiatives such as nutrition, breastfeeding, oral health and epidemiology. The Bureau has two epidemiologists that serve as consultants to all programs. They interface with epidemiological work done in other Bureaus inside the agency and with other organizations and efforts in the state. One epidemiologist serves as the State Systems Development Initiative project coordinator. Both epidemiologists coordinate all data analyses for the MCH/CSHCN needs assessment with an outside contractor. Both assist programs with assessments and evaluations, conduct research, and address epidemiologic needs of the BFH. Each of the Sections is attempting to build data capacity through staff training and education and rewrite of job descriptions to require data skills for new hires.

The Children & Families Section is responsible for: 1) Systems development activities for perinatal systems of care including coordination with Perinatal Association of Kansas; 2) Systems development for child, school and adolescent health care, in partnership with the Kansas Chapter of the American Academy of Pediatrics, Kansas School Nurse Association and others; 3) Maternal and Child Health grants to assist local communities to improve health outcomes for pregnant women and infants and for children and adolescents; 4) Women's Health Care and Family Planning - Systems of care and grants to communities to support the health of women in their reproductive years; 5) Other grants targeted to specific populations and needs - school nurse/public health nurse collaboration.

Children and Youth with Special Health Care Needs assumes the following responsibilities: 1) Systems development activities - promotes the functional skills of young persons in Kansas who have a disability or chronic disease by providing or supporting a system of specialty care for children and families including specialized services and service coordination, quality assurance, and community field offices; 2) Make a Difference Information Network (MADIN) - Assists children and adults including those with disabilities, their families and service providers to access information and obtain appropriate resources. MADIN serves as the MCH toll-free line; 3) State implementation grant for Integrated Community Systems for CSHCN; 4) Newborn Metabolic Screening - Assures identification and early intervention for infants with metabolic disorders.

The Children's Developmental Services Section includes the following programs: 1) Infant-Toddler Services (Part C of IDEA) - Promotes the early identification of developmental delay and disorders through child find, services coordination (case management), resource referral and development, and direct service provision for eligible infants and toddlers and their families; 2) Newborn Hearing Screening - Assures early identification of significant hearing loss in newborn infants including a hearing aid loaner program for young children; 3) Interagency coordinating Council - advisory committee to Part C of IDEA. Members are parents of children with special needs, legislators, early intervention service providers, state agencies, and community members. http://www.kansasicc.org/

The Nutrition and WIC Services Section includes the following programs: 1) Nutrition Services - Improves the health and nutritional well being of Kansans through access to quality nutrition intervention services including educational materials, consultation services, program coordination and referrals; 2) the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - Provides nutrition education, breast-feeding promotion and support, substance abuse education, nutritious supplemental foods, and integration with and referral to other health and social services; 3) Breastfeeding -- Peer Education Program - small grants to local agencies to assist with peer-to-peer education. This unit also supports the State Breastfeeding Coalition.

The State health agency is responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V [Section 509(b)]. When funds are allocated to other programs outside the BFH, the Bureau maintains legal contracts for the use of the funds, or in the case of funds allocated to other programs within the KDHE MOUs clarify the nature of the work that is done in support of the MCH priorities.

Official and dated organizational charts that include all elements of the Title V Program and how it fits within the state agency, clearly depicted, are on file in the State Human Resources office and are available in the attachment.

An attachment is included in this section.

D. Other MCH Capacity

Describe the number of location of staff that works on Title V programs. Include those that provide planning, evaluation, and data analysis capabilities. Include qualifications in the form of a brief biography of senior level management employees in lead positions. Also include number and role of parents of special needs children on staff. In addition, provide other MCH workforce information that may be available, such as FTEs at State and local levels, tenure of the State MCH workforce, and projected changes to the MCH workforce in the coming year.

The BFH has 57.5 full-time equivalent (FTEs) positions. Four (4) FTEs including 2 epidemiologists are located in administration. CYSHCN has 11.5 FTEs plus 4 Newborn Metabolic screening. This includes three RNs. Children & Families Section has 11 FTEs including 5 RNs. Children's Developmental Services has 8 FTEs in Part C and 4 in Newborn Hearing Screening. This includes one audiologist. There are a total of 15 FTEs in Nutrition and WIC including 5 nutritionists. None of these positions are out-stationed in local or regional offices.

MCH Block Grant funds provide salaries for 22.5 FTEs or 40% of the staffing in the Bureau. This breaks out to 4.0 FTEs in Administration, 9.5 FTEs in CSHCN, 6.0 FTEs in C&F Section, 2.0 in CDS, and 1.0 in WIC.

Since 2000, Linda Kenney has served as Director of the bureau and Kansas Title V Director. From 1989-2000 she served as Director of the Children and Families Section in the Bureau. She served briefly as director of the state breast and cervical cancer screening program and director of a state mental hospital-community transition project, case management supervisor for a community disability organization, and director of a local family planning clinic. She has served on the Board of the Kansas Public Health Association (KPHA), and on a number of state and federal advisory groups relating to maternal and child health. She holds an MPH degree in Health Services Administration from the University of Pittsburgh, Pennsylvania and a bachelor's degree from Indiana University. In addition to the four Section Directors, three other staff report to her including the two epidemiologists.

Marc Shiff serves as the State CYSHCN Director. He has a Master's of Public Administration degree from the University of Texas at Dallas with concentrations in Health and Public Management. His Bachelor of Science degree in Management and Social Science is also from the University of Texas at Dallas. Prior to his current position, he served as Director of Operations and Services for the KDHE Bureau of Disease Control and Prevention and as Programs Manager for the University of Kansas Medical Center, Kansas City, providing medical, nursing, and allied health continuing education oversight. He was appointed to the Governor's Commission on Autism Task Force, and is a member of the Kansas Department of Social and Rehabilitation Services Traumatic Brain Injury advisory board, Kansas Developmental Disabilities Council, Kansas Families Together Advisory Council, and past State Co-Chair of the Kansas Community Planning Group. Shiff was selected to particpate in the MCH Leadership Development program. Fifteen CYSHCN/NBS Topeka staff report to him and he provides CYSHCN program support and guidance to 7 field contractor staff in Kansas City and Wichita.

Ileen Meyer is a professional registered nurse with experience in services to the pediatric and young adult populations during her 35 year career in public health. She holds a Master of Science degree in Counseling Education from Emporia State University. She has extensive experience working with adolescent health and education issues. She joined KDHE as the Director of Children & Families Section in 2000. She is involved with the Kansas Chapter of the American Academy of Pediatrics and its specialty subcommittees, Kansas Perinatal Council, Kansas Suicide Prevention Steering Committee, Early Childhood Stakeholders Advisory Committee, Head Start Collaborative Stakeholders, Kansas Safe Kids Coalition, Kansas Action for Children, Kansas Fatherhood Coalition, and Kansas Works Interagency Coordinating Council. Meyer manages a staff of 10 FTEs (5 nurses, 2 program planning and evaluation, 1 data entry and 2 clerical).

The Section Director of the Children's Developmental Services section retired in April 2010 after serving 10 years in her position. The position is vacant at the time of this writing and a recruitment effort is underway.

David Thomason is the Director of Nutrition and WIC services. He has served in that capacity since 1998. From 1989 to 1998, he managed fiscal services and reimbursement in the Kansas Medicaid Program. David holds a Master's degree in Public Administration from the University of Kansas and a Bachelor of Science degree in Human Service Agency Management from Missouri Valley College. Thomason has completed the Kansas Public Health Certificate Program. He has served as President of National Association of WIC Directors (NAWD).
Thomason manages a staff of 15 FTEs (5 nutritionists, 1 RN, 2 information systems, 4 program analysts, 3 clerical).

BFH staffs have been appointed to a number of Governor's Initiatives: State Hunger Team, Blue Ribbon Task Force on Immunization, Bioterrorism Coordinating Council, and State Developmental Disabilities Council.
Other staff holds national offices: Sandy Perkins, WIC Nutritionist, is director of Association of State and Territorial Nutrition Directors; Jane Stueve is President of National Association of State School Nurse Consultants.

The only change to leadership in the BFH (the CDS Director) has been noted above.

The CYSHCN Family Advisory Council is comprised of parents and caregivers of children and youth with special health care needs. Efforts have been made to select families that represent geographical areas of the state, ethnic populations, and health categories supported by the State's Family Advocacy group, Families Together Inc. The CYSHCN Family Advisory members are regarded as expert consumers as well as partners and their opinions are sought and incorporated on a variety of issues. Examples include the evaluation and implementation of the 5 year needs assessment, how to best disseminate/update information to families, and input on the design of the toll free information line and web-based companion. Family Advisory Council meetings occur in-person and via teleconferences throughout the year to maximize family's engagement.

The CYSHCN - HRSA D-70 Integrated Community Systems grant "Systems in Sinc" Advisory Council links families and youth with special health care needs with information and services for YSHCN. As members of the Advisory Council, parents of youth with special health care needs are able to provide feedback and input on project activities to ensure that identified objectives are met. Consumers are the central focus of these efforts. Parents are also represented on the Quality Improvement team that will meet in Washington, D.C. in June 2010 to ensure parent participation and involvement on all levels of the grant project. Family members participated in the 8 regional town hall meetings and provided feedback and input on a variety of topics related to transition and health for youth with special health care needs. A Youth Advisory Council is in development to ensure youth participation and input is central to the project. Parents of our youth advisory members are provided with trainings or opportunities to share information and discuss important issues and topics related to their youth's transition and development.

E. State Agency Coordination

Coordination within the State Health Agency

MCH and CYSHCN work with a number of program areas on public health issues. Office of Local and Rural Health (Primary Care Cooperative Agreement, district nurse consultants, community health assessment coordination, Farmworker Health, Refugee Health, Trauma Registry), Bioterrorism and Preparedness, Bureau of Child Care Licensing (standards for health and safety in out of home care, inspections of residential facilities, state schools for deaf and blind and

birthing centers), Bureau of Consumer Health (childhood lead poisoning and environmental tracking and birth defects), Bureau of Health Promotion (Breast & Cervical Cancer Screening, Injury/Disability Program, Youth Tobacco Prevention, Diabetes Control, Kansas LEAN, Arthritis, 5 A Day, Kansas LEAN 21), Bureau of Epidemiology and Disease Prevention (HIV/STDs, immunizations).

There is good coordination with the Division of Health and Environmental Laboratories: Inorganic Chemistry (Lead Screening), Neonatal Metabolic Screening. There is a close working relationship with Center for Health and Environmental Statistics (perinatal outcome data, adequacy of prenatal care, hospital discharge data, and data linkages with Medicaid).

Coordination with Other State Agencies

Education and Social Services are the two State Human Services Agencies with whom MCH/CYSHCN frequently has contact. MCH works with the State Department of Education on health related issues for preschool and school-age children including guidance for school nurses and administrators (see the BFH website). The school nurse role has been expanded to include preventive and primary health care at school for children and youth who are at risk including the underinsured and uninsured. Delegation of nursing tasks to unlicensed school personnel is an ongoing education issue. Title V staff assist the State Education agency and Kansas Board of Nursing with this issue. Title V staff serves on the Statewide Education Advisory Council and attends the special education administration staff meetings. This collaboration has served to strengthen the health services components for special health care needs students in local school districts.

The federal legislation on inclusion has necessitated the reeducation of school nurses and training for allied school personnel in the provision of care to medically complex children. "Guidelines for Serving Students with Special Needs Part II: Specialized Nursing Procedures," helps local education agencies provide services to CYSHCN students. This was a collaborative project between Title V and the State Department of Education. Standards for CYSHCN have been developed are also underway for early childhood education programs and child care providers. Others areas of significant collaborative efforts include: Part B of IDEA, School Readiness, and School Nutrition.

Schools, health departments, and primary care providers are encouraged to use "School Nursing and Integrated Child Health Services: A Planning and Resource Guide" in tandem with Bright Futures as the standard for provision of public health services to children. Multiple professional development opportunities are provided utilizing the statewide Area Health Education Centers (AHECs) and local area education service centers as training sites. It is anticipated that a day long video conferencing format will become the norm with facilitators available at times and sites convenient for any school district.

MCH/CYSHCN staff have frequent contact with Medicaid and SCHIP (HealthWave). MCH/CYSHCN assists with outreach and enrollment efforts, reviews data relating to utilization patterns, assists with provider recruitment, promotes standards of care, and assures provider training. Local MCH agency dollars expended on Maternal and Child Health services are utilized as match for federal Medicaid dollars to provide prenatal case management, nutrition and social work service for high risk women as well as newborn postpartum home visits. These and other collaborative arrangements are formalized in the Interagency Agreement (updated in 2009 to include HIPAA and data sharing). MCH/CYSHCN staffs meet monthly with Medicaid and HealthWave staff to discuss mutual concerns and to plan for identified service needs. Medicaid includes information about the WIC program in its notices to clients reminding them of immunizations due. Medicaid and Family Planning did considerable work on a family planning waiver request that was never forwarded to CMS.

MCH/Infant-Toddler Services staff, in collaboration with Medicaid staff, has developed a Medicaid

reimbursement fee for a service system of early intervention services (such as occupational therapy, physical therapy and speech-language therapy) through a specially designed Infant-Toddler early intervention Medicaid providership. Training was provided to teach the Infant-Toddler Networks how to use their providership numbers to bill for these services. In 1999, the Infant-Toddler Services Medicaid providership was enhanced to include targeted case management (service coordination) as a reimbursable service for eligible infants and toddlers. Steps were implemented to add developmental intervention services as a Medicaid reimbursable service as well.

For the high-cost services to special needs children, the interagency agreement directs mutual referrals, cross program education, fiscal responsibilities and case management services for children participating in both Medicaid and CYSHCN programs. Title V implemented linkages with the Medicaid and EDS/MMIS System so that CYSHCN staff has direct access to Medicaid information on children eligible for both Title V and Title XIX/XXI.

An interagency agreement delineates mutual responsibilities between Title V and SRS focusing on referral of Supplemental Security Income (SSI) children and youth between the two agencies. A third party, the Developmental Disabilities Center assists in design of materials to improve reporting of reliable information to make an accurate determination of eligibility for SSI benefits, and recruitment and expansion of the SSI provider pool for SSI consultative examinations. Another development is training for providers who give consultative evaluations. CYSHCN staff has a B agreement in place that allows increased access to SSA data.

Through the Farmworker Health Program and with Medicaid coordination (described in the interagency agreement), children and families of migrant and seasonal farm workers receive primary, preventive, acute and chronic care services at seventy-five clinic sites. Title V staff coordinate with Farmworker Health staff in the Office of Local and Rural Health to identify methods to maximize use of individual program funds to assure access to prenatal care and specialty care/follow up for farmworkers and their families.

Title V works with Employment Preparation Services in SRS on issues such as teen pregnancy prevention and public health assistance for indigents. Title V has worked with Alcohol and Drug Abuse Services on a number of substance abuse issues including prevention programs for youth, identification and intervention for pregnant women, and treatment facility standards for pregnant substance abusers. Title V has worked with Mental Health on a state plan for adolescent health, youth suicide and other issues. MCH serves on the State Developmental Disabilities Council located in SRS. KDHE's Child Care Licensing works with Foster Care regarding quality of child placements. CYSHCN works with Rehabilitation Services (Vocational Rehabilitation), Disabilities Determination and Referral Services.

Other State agencies with whom MCH/CYSHCN collaborates include the following: Kansas Department of Insurance on issues of public and private insurance coverage for the maternal and child population. MCH works with the Kansas Department of Transportation (KDOT) and the Kansas Board of Emergency Medical Services through the Injury Prevention program on data and policy issues. MCH/CYSHCN has participated with the Kansas Advisory Committee on Hispanic Affairs and the Kansas African American Affairs Commission on cultural and linguistic competence issues. MCH has assisted the Kansas Department of Corrections on health standards for youth facilities, finding providers of prenatal care for pregnant inmates.

Coordination with Other Agencies and Organizations

University and other collaborations include the following: University of Kansas; Bureau of Child Research/Center for Independent Living; Life Span Institute; University Affiliated Programs, Kansas University Center for Developmental Disabilities, Lawrence and Parsons; Developmental Disability Center/LEND Program; School of Medicine; School of Social Welfare; Preventive Medicine; Mid-America Poison Control Center; Area Health Education Center; Wichita State

University; Kansas State University; Cooperative Extension Kansas Nutrition Network; University of Kansas School of Medicine - Wichita, MPH Program; Heartland Regional Genetics Consortium (to develop State genetics plan).

MCH works with professional groups, private non-profit organizations and others such as: March of Dimes; American Academy of Pediatrics - Kansas Chapter; Academy of Family Physicians; Kansas Children's Service League; Children's Coalition; Kansas Adolescent Health Alliance; Dietetic Association of Kansas; Kansas Action for Children; Families Together, Inc; Kansas Hospital Association; Assistive Technology Project of Kansas; Kansas Medical Society; Kansas Lung Association; SAFE Kids Coalition; Kansas Immunization Action Coalition; Kansas Health Foundation (KHF); Sunflower Foundation; Kansas Health Institute; Kansas Public Health Association; Perinatal Association of Kansas; SIDS Network of Kansas; Mexican American Ministries; Campaign to End Childhood Hunger; United Way; Kansas Head Start Association; Kansas Nutrition Council; Kansas Dental Association; Kansas Association of Dental Hygienists; United Methodist Health Ministries; Fetal Alcohol Syndrome pilot project; National School Readiness Indicators Workgroup; Missouri D70 project; Kansas Head Start Collaboration Project.

There is an interdependent relationship between the state and local public health agencies. Kansas' 99 local health departments (LHDs) serve all 105 counties. The local health departments are organized under city and/or county government. They are mostly reliant on county mill levy funding, although some modest per capita state formula funds are provided to each county. Contracts and grants from the state health agency provide a third significant source of funding. The staffs of the Kansas Association of Local Health Departments assure coordination with KDHE programs. LHD representatives serve on all KDHE workgroups and committees with potential impact on LHDs.

MCH Block Grant dollars support regional public health nurse activities: regional public health meetings that serve as a forum for updates; technical assistance to local health departments regarding administrative issues, including billing, grant writing, budget, human resources, information systems, policy/procedures, HIPAA; technical assistance to local health departments regarding public health practice issues, including public health performance standards and competencies, as well as the MCH Core Public Health Services; collaboration with Heartland Center for Public Health Preparedness and University of Kansas School of Medicine, Department of Preventive Medicine and Public Health, for training sessions on cultural competency and diversity, risk communication, informatics, and public health law, through Kansas Public Health Grand Rounds series; distribution of resource publications and information necessary to support practice, including Connections Newsletter, Kansas Rural Health Information Service (KRHIS), OLRH website, Public Health Nursing and Administrative Resources Manual, and Domestic Violence Manual. Public health nurses maintain ongoing partnerships to support education/training for public health with state and regional training partners, including: Heartland Center for Public Health Preparedness, St. Louis University School of Public Health, University of Kansas School of Medicine, KU Public Management Center, Professional Associations, and Kansas Association of Local Health Departments (KALHD). Ongoing training activities include the Kansas Public Health Certificate Program, and the Kansas Public Health Leadership Institute.

Newborn Screening staff work closely with Heartland Genetics and Newborn Screening Regional Collaborative funded by MCHB/HRSA. Staff serves on the Advisory Committee for the Heartland Collaborative and on the Newborn Screening committee. Heartland has provided funding for Kansas to complete a State Genetics Plan. Stakeholders participate in this planning process along with MCH/CYSHCN staff, Cancer Control and Prevention and Chronic Disease staff. The stakeholders have met for two face-to-face meetings and participated in conference calls. The plan will be finalized in 2010.

Coordination with other Kansas MCHB Grants

KDHE staff is involved in numerous ways with grants that are awarded by MCHB to the State of Kansas. MCH coordinates with the Kansas City Healthy Start awarded to the MCH Coalition of Greater Kansas City and with the Healthy Start Initiative awarded to the Wichita-Sedgwick County Health Department the Directors of these two programs serve on the state Blue Ribbon Panel on Infant Mortality. The Kansas University Affiliated Program at the University of Kansas Medical Center works closely with the CYSHCN program staff and contract staff actually share office space with the program. Currently MCH staff serves on the advisory board for the Traumatic Brain Injury Implementation grant and have served in the past with the Healthy Child Care Kansas grant. Staff within the bureau directly administers the State Early Childhood Comprehensive Systems and the Universal Newborn Hearing Screening. MCH works closely with the Bureau of Oral Health on its grants, Emergency Medical Services for Children (EMSC) Partnership and other grants.

Collaborative activities between newborn hearing screening (Sound Beginnings) and Part C of IDEA local agencies have decreased the loss to follow-up between diagnosis and early intervention. Collaboration with the KU Area Health Education Centers has facilitated ten regional trainings for over 150 nursing and laboratory staff who are involved in the collection of blood spot cards for newborn screening. Collaboration between SIDS Network of Kansas and Healthy Start Home Visitors has helped provide safe sleep environments for infants at risk of SIDS and other sleep related deaths. 'Cribs for Kids' were distributed through this joint effort. Collaboration with the data people in the state social service agency (SRS) has resulted in some program changes and explanation of the trends we see particularly for TANF. There has been ongoing sharing of data between SRS and KDHE and future meetings are planned with the possibility of MCH epidemiologists assisting with analysis of their data.

There has been strong collaboration among KDHE, KSDE, Kansas In-service Training System (KITS), local infant toddler networks and statewide school districts' Part B programs, to develop, implement, and provide user training for an outcomes web system that tracks a child's functional progress in three developmental outcomes.

CYSHCN and newborn screening have worked closely together during the expansion from four to 29 conditions. The newborn screening advisory council is a very strong group of specialty doctors, parents and staff that meet four times a year to assess program process and outcomes. Information about new conditions has been shared to assure families receive diagnoses and treatments for their infants. Collaboration with the federal Healthy Start projects in Kansas City and Wichita has helped bring the state up to date about the value of Fetal-Infant Mortality Review. Collaboration with the Perinatal Association of Kansas has enhanced multi-disciplinary expertise to the state agency's approach to perinatal care and education activities. Consultation is provided to the department to help improve state perinatal outcomes. The state MCH/CYSHCN agency and the Kansas Chapter of the AAP adopt strategies to improve child and adolescent health outcomes.

The Kansas Reconvene Team in which state health and education agencies obtained training through the National Alliance of State and Territorial AIDS Directors, National Coalition of STD Directors, and others was instrumental in advancing a plan for building capacity in the areas of disparities and peer education. The fatherhood summit was a collaborative activity in which JJA, Catholic Social Services, KPIRC, and others developed a common goal, shared resources, provided educational events for families and providers to help people better care for their children.

A strong ongoing collaboration is between family planning and the breast cancer program, Early Detection Works. These two programs work together to help low-income women get follow-up care on their abnormal Pap smears. The child care health consultation training was an important collaboration among a variety of organizations/experts, Wichita State University, and KDHE. The project was a direct result of the collaboration between MCH and all the signators to the Kansas Early Childhood Comprehensive Systems State Plan. Another collaboration worth mentioning is

that formed with the conveners of the SECCS Plan. This resulted in training for MCH/CYSHCN staff on Results-Based Accountability. A collaborative activity with K-State Research and Extension Department resulted in downsizing and redefining the activities of the Kansas Nutrition Network, the USDA State Nutrition Action Plan, and the annual MOU review and revision. The Kansas State Department of Education, Special Education Services and Children's Developmental Services have forged a close relationship attending each other's meetings. MCH participates in their annual Leadership Conference. Monthly meetings continue to build this important partnership.

Kansas business case for breastfeeding train the trainer grant has helped us build a coalition of partners committed to workplace reform and policies that better support families. The Medicaid/MCH Interagency Agreement defines collaborative activities between the two programs as required by law. In 2009, an update to the document helped to strengthen our relationship. These are among the numerous collaborative activities and practices engaged in by the Kansas Title V.

F. Health Systems Capacity Indicators

Introduction

Kansas monitors trends in Health Systems Capacity Indicators and utilizes the data to answer the following questions:
what has influenced Kansas' ability to maintain or improve the data and the systems assessed;
what strategies are/could be used to improve capacity in these areas; and
what interpretations may be made from the data.
Also, for HSCI 09A, what is the link between the SSDI grant and improved access to data.

Kansas Maternal and Child Health (MCH) is building data infrastructure, epidemiological capacity, and products of analysis in order to carry out core public health assessment functions. We continue to improve Kansas MCH data capacity by: 1) improving data linkages between birth records and other data sets such as infant death certificates, Medicaid eligibility and/or paid claims files, WIC eligibility files, and new born metabolic screening files; 2) improving access to hospital discharge data, Youth Risk Behavior Survey (YRBS) data, Birth Defects Surveillance System (BDSS) data, Pregnancy Risk Assessment Monitoring System (PRAM) data, and Children and Youth with Special Health Care Needs (CYSHCN) program data; and 3) assuring ongoing MCH state needs assessment and review of performance/outcome measures.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	31.3	33.7	33.1	26.9	26.9
Numerator	588	655	649	545	545
Denominator	187949	194100	196138	202529	202529
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

The 2009 column is populated with 2008 data. 2009 data will be available Summer 2011.

Notes - 2008
Data Source: Kansas hospital discharge data, Kansas Hospital Association. Accessed through the Center for Health and Environmental Statistics, KDHE.

Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public. Only discharges with asthma as a primary diagnosis were included.

Notes - 2007
Data Source: Kansas hospital discharge data, Kansas Hospital Association. Accessed through the Center for Health and Environmental Statistics, KDHE.

Data includes hospital discharges of Kansas residents from non-federal and non-state short-term (average length of stay less than 30 days) general and specialty hospitals whose facilities are open to the general public. Only discharges with asthma as a primary diagnosis were included.

Narrative:
In Kansas, the rate of asthma hospitalizations has decreased (18.7%) from 33.4/10,000 in 2007 to 26.9/10,000 in 2008. For the years 2005-2008, a decreasing trend was detected.

The disparity between non-Hispanic black children, white non-Hispanic children, and Hispanic children is of continuing concern. The hospitalization rate for black non-Hispanic children is approximately two times that of white non-Hispanic or Hispanic children (all races), which may indicate poor access to medical homes, the need for better quality of care for children diagnosed with asthma, poverty and living conditions, and other factors.

In 2004, the Office of Health Promotion in KDHE obtained a grant from CDC to develop a state asthma plan and program. The Kansas Asthma Program (KAP) Work Plan is organized around six proposed goals for the 5-year project period to be completed by August 31, 2014: 1) An operative statewide organization will define and guide Kansas asthma initiatives; 2) Regional and state level asthma data for Kansas will be collected, analyzed, and disseminated; 3) A comprehensive evaluation plan will be designed and implemented; 4) Reduce disparities among populations disproportionately affected by asthma; 5) Reduce state asthma hospitalization rate; and 6) Increase the proportion of people with current asthma who report that they have received self-management education. More information can be found on the internet at http://www.kdheks.gov/bhp/download/Asthma_burden.pdf and http://www.kdheks.gov/bhp/download/Addressing_Asthma_in_Kansas.pdf

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.6	88.7	89.4	89.4	71.5
Numerator	16457	16834	17140	17295	14043
Denominator	18778	18968	19177	19351	19638
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2008-09/30/2009 (FFY 2009).

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2008
DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2007-09/30/2008 (FFY 2008).

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2007
Data Source: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Narrative:
In FFY 2009, 71.5% of Medicaid-enrolled infants received at least one initial or periodic screen. (The decline is due to problems with the encounter data. The 2009 data includes Fee-For-Service only and does not include the Managed Care data. Work is being done to improve encounter data and it is anticipated that this will be available later in 2010 (winter).

Overall, there has been much improvement in getting infants into care. For the years 2000-2008, there is a significantly increasing trend detected.

The number of enrolled infants (denominator) continues to increase each year, as does the number actually getting into services (numerator).

Families are linked with medical homes through local MCH agency services such as M&I and Healthy Start. MCH and CYSHCN coordinate efforts with both public insurers (Medicaid, HealthWave) and private insurers, and also with private providers (family practitioners, pediatricians

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	70.3	67.4	38.3	66.0	58.8
Numerator	289	244	158	268	231

Denominator	411	362	412	406	393
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data Source: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2008-09/30/2009 (FFY 2009)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2008
Data Source: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2007-09/30/2008 (FFY 2008)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

Notes - 2007
Data Source: Kansas Medical Assistance Program reporting system, Well Child for HW21 report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Total eligibles receiving at least one initial or periodic screen.
Denominator=Total eligibles who should receive at least one initial or periodic screen.

SCHIP was temporarily impacted by the DRA citizenship documentation requirements during SFYs 06 and 07. It reduced the number of enrollees, delayed reauthorization of cases, and likely lowered the number of services provided.

Narrative:
The Kansas Health Policy Authority continues to prioritize funding for SCHIP services for eligible children. The recent decline in 2009 is a data pull error. KHPA is in the process of debugging their system to pull both Managed Care and fee for service data, but this data was not available during the time of this grant's submission. The corrected data will be available winter 2010

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	79.2	78.5	77.4	77.6	77.6
Numerator	28283	28831	30175	30573	30573
Denominator	35724	36734	38963	39423	39423
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Bureau of Public Health Informatics, KDHE

Numerator = Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
Denominator = All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

Notes - 2007
Data Source: Center for Health & Environmental Vital Statistics, KDHE

Numerator = Number of resident women (15-44) during the reporting calendar year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.
Denominator = All resident women (15-44) with a live birth during the reporting calendar year for which prenatal visits, date of first prenatal visit and date of last menses were reported on the birth certificate.

Narrative:
The percent of Kansas women with a birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index (adequate and adequate plus prenatal care) was 77.6 percent in 2008, a slight increase from the previous year (77.4%). Over the 9 year period (2000-2008), there is a significantly decreasing trend detected. In the previous 9 years (2000-2008), this percent remained essentially the same in the years 2002 through 2004. When comparing 2005 and 2006 Kansas data, there was a slight decrease (0.9%).

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	75.5	95.7	93.6	81.0	83.1
Numerator	196212	220505	218191	202289	213709
Denominator	259866	230444	233207	249763	257147
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

Data Source: Medicaid paid claims data file, Kansas Health Policy Authority (calendar year 2009).

Numerator = # of unduplicated consumers =257,147
Denominator = # of unduplicated Medicaid beneficiaries = 213,709

Percent = 120.3%

Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2007 can be paid in 2008, and services in 2008 can be paid in 2009. Therefore, consumer counts are higher than beneficiary counts.

Notes - 2008
The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

Data Source: Medicaid paid claims data file, Kansas Health Policy Authority (calendar year 2008).

Numerator = # of unduplicated consumers =249,763
Denominator = # of unduplicated Medicaid beneficiaries = 202,289

Percent = 123.5%

Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2006 can be paid in 2007, and services in 2007 can be paid in 2008. Therefore, consumer counts are higher than beneficiary counts.

Notes - 2007
The numerator and denominator are entered in reverse. This causes the percentage to exceed 100%.

Data Source: Medicaid paid claims data file, Kansas Health Policy Authority (calendar year 2007).

Numerator = # of unduplicated consumers = 233,207
Denominator = # of unduplicated Medicaid beneficiaries = 218,191

Percent = 106.9%

Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2006 can be paid in 2007, and services in 2007 can be paid in 2008. Therefore, consumer counts are higher than beneficiary counts.

Narrative:
Please note that for 2007, 2008 and 2009, the numerator and denominator are entered in reverse (because the percentage cannot equal 100%). The number of Medicaid-enrolled children receiving at least one service increased from 249,728 (106.9%) in 2008 to 257147 (113.5%) in

2009.

Numerator: # of unduplicated consumers
Denominator: # of unduplicated Medicaid beneficiaries

Consumer is any person with a paid service during a time period (including capitation payments for managed care plans which may not indicate actual utilization of services), and that Kansas has a 12-month timely filling requirement, so services performed in 2007 can be paid in 2008, and services in 2008 can be paid in 2009.

Beginning with SFY 2007, Kansas Department of Social and Rehabilitation Services (SRS) implemented a PIHP (Prepaid Inpatient Health Plan) and PAHP (Prepaid Ambulatory Health Plan) waiver for substance abuse treatment and mental health services. With those waivers, all Medicaid persons not in a nursing home or incarcerated are now enrolled in a managed care organization for these services and a capitation payment is made for each person, each month. The timely filling requirements and the newer waiver payments may help explain why consumer counts are higher than beneficiary counts.

For timely data, claims are best reported on a "date of payment' basis, instead of a "date of service' basis. Medicaid timely filing rules allow for a claim to be submitted for payment up to 12 months after the date of service. This timing often creates situations where consumer counts are higher than beneficiary counts for a given month. This can be seen in Kansas Health Policy Authorities (KHPA) own publically reported counts:
http://www.khpa.ks.gov/medicaid_reports/download/MARFY2011.pdf

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	50.5	53.0	53.8	56.3	58.1
Numerator	20835	22649	22791	24094	26380
Denominator	41252	42710	42376	42826	45409
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2008-09/30/2009 (FFY 2009)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Notes - 2008
DATA SOURCE: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2007-09/30/2008 (FFY 2008)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Notes - 2007
Data Source: Kansas Medical Assistance Program reporting system, KAN-Be-Healthy annual participation report, report period: 10/1/2006-09/30/2007 (FFY 2007)

Numerator=Number of eligible receiving any dental services.
Denominator=Number of individuals eligible for Kan Be Healthy.

Narrative:
Kansas Health Policy Authority (KHPA) and Medicaid are committed to ensuring the health and proper development of children. However, the signficant gains made to get children in service may be threatened by the recent reductions in Medicaid reimbursements starting in 2010.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	36.2	100.0	100.0	100.0	100.0
Numerator	2196	6790	6335	6822	7339
Denominator	6072	6790	6335	6822	7339
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
DATA SOURCE: Healthy and Ready to Work National Resource Center. Table—Number and percentage distribution of children in Kansas receiving federally administered SSI payments, by selected characteristics, December 2009. Further information can be found at http://www.hrtw.org/youth/data.html#ssi

NOTE*
Title V no longer has access to SSA Data. Starting FY2006, a proxy measure is used. All children 16 years or less who are SSI recipients are required to enroll in Medicaid. It assumed that enrollees receive rehabilitative services.

Notes - 2008
DATA SOURCE: Healthy and Ready to Work National Resource Center. Table—Number and percentage distribution of children in Kansas receiving federally administered SSI payments, by selected characteristics, December 2008. Further information can be found at http://www.hrtw.org/youth/data.html#ssi

Title V no longer has access to SSA Data. Starting FY2006, a proxy measure is used. All children 16 years or less who are SSI recipients are required to enroll in Medicaid. It assumed that enrollees receive rehabilitative services.

Notes - 2007

Title V no longer has access to SSA Data. Starting FY2006, a program measure is used. All children 16 years or less who are SSI recipients are required to enroll in Medicaid. It assumed that enrollees receive rehabilitative services.

Narrative:
The CYSHCN program has a good relationship with the Kansas Department of Social and Rehabilitative Services where the Kansas Disability Determination agency is housed. As a result of changes in SSA requirements in 2005, the CYSHCN no longer receives monthly printouts or Disability Determination forms for those clients in Kansas receiving SSI. CYSHCN continue to have access to SSA data screens that allow staff to verify current eligibility. The CYSHCN program has worked with the Regional SSA office to continue the data screens with modification of data sharing agreements on an annual basis.

An application for the CYSHCN program continues to be sent to families of children who receive SSI and are not medically eligible for the CYSHCN program. No new referrals are formally sent to CYSHCN.

This year, 100% of State SSI beneficiaries less than 16 years of age received rehabilitative services from the State CYSHCN program. This is because all children are eligible for Medicaid in Kansas and Medicaid provides a full coverage of services.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	8.4	6.6	7.1

Notes - 2011
Data source: Birth certificate (resident) data, 2008. Bureau of Public Health Informatics, KDHE.

Live births with unknown/missing "principal source of payment for this delivery" were excluded from this analysis

Narrative:
According to 2008 birth certificate data, Medicaid paid for the delivery of 10,689 (25.6%) Kansas live births. There is some indication that this number/percent may be too low. The payer may be classified as self pay at the time the birth certificate data is collected and later designated Medicaid (SOBRA). The payer was known in 95.9% of live births.

Birth certificate data (2008) indicates 7.1% of Kansas births (where payment source is known) were low birthweight. For Medicaid births, 8.4% were low birth weight compared to 6.6% for non-Medicaid births.

Studies show that income status impacts both health status and access to care. Medicaid data for Kansas support this. Medicaid enrolled women are least likely to have positive birth outcomes possibly due to greater likelihood of poor preconception health, preconception and prenatal risk behaviors, limited access to early prenatal care and social supports, as well as possible greater

exposure to prenatal stress.

MCH provides medical prenatal care at a few local sites and prenatal care coordination services to low-income and high risk women. Healthy Start home visitors link women and their families with community services and supports.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	matching data files	9.7	5.7	6.8

Notes - 2011
Data source: Linked death and birth file, 2008 death cohort. Bureau of Public Health Informatics, KDHE.

Infant deaths with unknown/missing "principal source of payment for this delivery" were excluded from this analysis

Narrative:
In 2008, the infant mortality rate was highest for the Medicaid service population (9.7 per 1,000 live births) and lowest for the non-Medicaid population (5.7). The overall infant mortality rate for Kansas was 6.8 (where payment source is known).

The MCH program has collaborated with the Kansas City federal Healthy Start Program to conduct Fetal-Infant Mortality Review (FIMR) recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) as a best practice strategy in helping communities identify the systems issues that need to be addressed to prevent infant deaths.

Since 2007, the KDHE Bureau of Public Health Informatics (BPHI) and the federal Healthy Start program in Wichita (Sedgwick County Healthy Babies) assisted the community in addressing this public health concern. In 2008, SCHD designated a staff person to lead the FIMR project. In 2009, strategic partnerships were formed and project partners were recruited to formally develop the Sedgwick County FIMR. The national FIMR model that SC FIMR followed in the development of the program (ongoing) promotes a 3-step approach: Gathering fetal and infant death data (thru medical chart abstraction and a family interview), presentation of individual case data to a Case Review Team (CRT) who make recommendations for community program and policy change, and advocacy by a Community Action Team (CAT).

In April, 2010, SCHD and KDHE, Bureau of Health Informatics, entered into a contract that will allow the 2 agencies to work together to continue the SC FIMR thru 2012. The role of SCHD will be to carry out the functions of a local FIMR (including chart abstractions and the work of the CRT and CAT; the role of KDHE will be to provide notification of death when an infant death occurs, provide technical assistance and data analysis support. In May, 2010, SCHD Healthy Babies hired a part-time chart abstractor. In early, 2010, SIDS Network of Kansas committed to conducting the FIMR maternal interviews with the capacity to conduct 40-60 interviews per year. Beginning in July, 2010, SC FIMR CRT will begin ongoing monthly meetings to review current

fetal and infant deaths. SC FIMR will continue to develop the CAT to promote community change.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	58.7	77	72.1

Notes - 2011
Data source: Birth certificate (resident) data, 2008. Bureau of Public Health Informatics, KDHE.

Live births with unknown/missing "principal source of payment for this delivery" were excluded from this analysis

Narrative:
In 2008, 72.1% of Kansas infants were born to women receiving prenatal care (PNC) beginning in the first trimester of pregnancy (where payment source is known). Only 58.7% of Kansas Medicaid infants were born to women receiving PNC in the 1st trimester of pregnancy. Those not participating in Medicaid had the best access to early prenatal care at 77.0%.

The eligibility level for pregnant women for Medicaid coverage in Kansas is 150% federal poverty level (FPL). Low-income undocumented women can qualify for Medicaid coverage under the Sixth Omnibus Budget Reduction Act (SOBRA). Both poverty status and undocumented status have been associated with delayed prenatal care.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to	2008	payment source from birth certificate	65.4	79.8	76

expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Notes - 2011
Data source: Birth certificate (resident) data, 2008. Bureau of Public Health Informatics, KDHE.

Live births with unknown/missing "principal source of payment for this delivery" were excluded from this analysis

Narrative:
In 2008, 76.0% of all live births (where payment source is known) were to women with adequate or adequate plus prenatal care. For Medicaid-enrolled women, 65.4% had adequate or adequate plus prenatal care, compared to 79.8% for non-Medicaid livebirths.

Medicaid status is an indicator of poverty. Medicaid births include those covered by Sixth Omnibus Budget Reduction Act (SOBRA) for labor and delivery of undocumented women who meet the income eligibility requirements. Both poverty status and undocumented status have been shown to be associated with delayed prenatal care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Notes - 2011
DATA SOURCE:
Kansas Health Policy Authority. Medicaid program eligibility requirements, CY2009.

Notes - 2011
Kansas Health Policy Authority. Healthwave program eligibility requirements, CY2009.

Narrative:
Kansas remains committed to serving those at levels recommended by the federal government. However, effective 1 January 2010, Kansas Healthwave (SCHIP) expanded eligibility to 241% of 2008's Federal Poverty Level (FPL).

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**

Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 200 200

Notes - 2011
DATA SOURCE:
Kansas Health Policy Authority. Medicaid program eligibility requirements, CY2009.

Notes - 2011
Kansas Health Policy Authority. Healthwave program eligibility requirements, CY2009.

Narrative:
Kansas remains committed to serving those at levels recommended by the federal government while still being able to balance its budget. Effective 1 January 2010, Kansas Healthwave (SCHIP) expanded elgibility to 241% of 2008's Federal Poverty Level (FPL).

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Notes - 2011
DATA SOURCE:
Kansas Health Policy Authority. Medicaid program eligibility requirements, CY2009.

Notes - 2011
Kansas Health Policy Authority. Healthwave program eligibility requirements, CY2009.

Narrative:
Kansas remains committed to serving those at levels recommended by the federal government while still being able to balance its budget. Effective 1 January 2010, Kansas Healthwave (SCHIP) expanded elgibility to 241% of 2008's Federal Poverty Level (FPL).

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR	**Does your MCH program have**	**Does your MCH program**

SURVEYS	the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2011

Narrative:
The MCH program has access to database linkages, registries and surveys as above except for the following: annual linkage of birth certificates and WIC, annual linkage of birth certificates and Medicaid Eligibility or Paid Claims files, and survey of recent mothers at least every two years (Prenatal Risk Assessment Monitoring System - PRAMS). A birth defects surveillance (BDSS) module is completed that interfaces with the CYSHCN web-based system. This will improve our standing with respect to the CDC standards for birth defects surveillance systems - a technical assistance from CDC is scheduled for August 2010. Hospital discharge survey data are available for at least 90% of in-State discharges.

The MCH program has direct access to data files for: infant birth certificates, infant death certificates, birth defects, hospital discharge data, WIC, newborn screening files, and Medicaid Eligibility and Paid Claims files.

The Bureau of Public Health Informatics (BPHI) and MCH are in the initial stages of creating a linked birth, Medicaid, WIC and hospital discharge dataset for 2007 events. Linked birth-infant death history files back to 1996 have been created and are in the process of being shared via network resources. This would facilitate access by other staff to the linked and de-identified data. Linkages are created for each new data year. BPHI continues to work on providing networked access to the linked files and other special data files. MCH and BPHI continue to collaborate on

analysis and interpretation of reports. Generation of new reports will be considered and utilization of regularly developed reports will be improved.

The current link between birth certificates and newborn screening files is inefficient, requiring many steps between initial data entry and production of final reports. The goal is to have an electronic link between the two systems by the end of the 2010 calendar year. This link will provide newborn demographic information directly from vital to the laboratory database eliminating a majority of missing information, manual data entry, and tracking every newborn screened.

The recently amended law (HB 2454) on the use of data contained in vital statistical records broadens the use of Vital Statistics data for maternal and child health surveillance and monitoring. PRAMS (Pregnancy Risk Assessment Monitoring System) and FIMR (Fetal Infant Mortality Review) development efforts are underway.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Kansas Youth Tobacco Survey	3	Yes

Notes - 2011

Narrative:
YRBS: The YRBS is part of a biennial national effort led by CDC and is conducted by the Kansas State Department of Education (KSDE) and KDHE in partnership with local school districts. The YRBS monitors health risks and behaviors in six categories, which are related to the leading causes of mortality and morbidity among both youth and adults. Data is collected on behaviors that contribute to physical activity, nutrition, tobacco use, alcohol and other drug use, violence and injuries, and sexual behaviors. During the spring of 2005, KSDE and KDHE conducted the YRBS in 41 Kansas high schools. For the first time in Kansas YRBS history, weighted data was obtained. The surveys were completed by 1,652 students in grades 9 through 12. In 2007, Kansas again achieved weighted data for the YRBS. In that school year, the YRBS was completed by 1,733 students in 49 public schools. The Kansas 2009 YRBS was completed by 2,026 students in 51 public schools, grades 9 through 12. Participation once again resulted in weighted data and with three consecutive cycles of data, trend analyses were conducted. The YRBS results provide useful information that can be used to make important inferences about 9th through 12th grade students statewide due to the research based method of random selection used to gather the data. Compiled results from the 2005, 2007 and 2009 Kansas YRBS can be found on the Kansas Coordinated School Health Program website at www.kshealthykids.org.

YTS: The purpose of the Kansas Youth Tobacco Survey (YTS) is to monitor the prevalence, attitudes and knowledge, and other aspects of tobacco use, physical activity, and nutrition among adolescents in grades 6 to 12. Survey methodology includes a stratified two-stage cluster sampling design with first stage of random selection of schools in Kansas containing grades 6 to 12 and then second stage of random selection of classes within each school.

These data are important for determining burden of tobacco use, related social factors, perception about tobacco use and initiation susceptibility among youth. Data are also used to determine tobacco control programming and evaluation of program components for their effectiveness in Kansas. The YTS also provide data for nutrition and physical activity components

of Health Promotion in Kansas.

The Kansas YTS is conducted once every two school years. The Kansas YTS was conducted in 2000, 2002, 2006, 2007/2008, and 2009. Community specific Kansas YTS were conducted in 9 communities in 2000, in 7 communities in 2002, in 4 communities in 2004, and in 17 communities in 2006 and 2007/2008 surveys. The surveys have been analyzed, and the associated reports and fact sheets are provided to the county partners. 2008/2009 Kansas YTS was conducted as a state-level survey. The weighted analysis of 2008/2009 survey (middle and high school surveys) and development of report is in progress.

IV. Priorities, Performance and Program Activities

A. Background and Overview

In Kansas, high standards of accountability apply to all maternal and child programs. This is due to scarcity of resources at the federal, state and local levels and through other funding sources such as foundations. Legislators and others require regular reports on best practices, performance and outcomes. Increasingly data is linked to funding decisions, mostly to achieve efficiencies but also to improve outcomes for certain target populations. The State budget including the BFH budget is based on performance and outcome measures linked to the spending plan. The Legislature requires strict accountability through annual reports and special reviews. An example of a special review is the Legislative Post Audit study on KDHE programs that address low birthweight. Other funding sources such as the Children's Cabinet which provides oversight of Tobacco Settlement funds requires each recipient of funds to provide an annual program evaluation summary including performance and outcome data.

Since 1999 BFH has included performance plans and performance information in its federal MCH budget submission. BFH submits annual reports to Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) on the actual performance achieved compared to that proposed in the performance plan. This Section of the Kansas MCH Services Block Grant Application describes how the State-Local partnership will implement the federally-required performance reporting requirements.

The MCH Block Grant Performance Measurement System is an approach utilized by Kansas that begins with the state/local needs assessment and identification of priorities. Evidence-based strategies are identified to address each priority. The strategy(ies) selected are formalized in logic models and workplans. This culminates in improved outcomes for the maternal and child population.

After Kansas establishes its priority needs for the five-year statewide needs assessment, programs are developed based on best practices, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH Pyramid: direct health care services, enabling services, population-based activities, and infrastructure-building activities. Since there is flexibility available to Kansas in implementing programs to address priority needs, the program activities or the role that MCH plays in the implementation of each performance measure may be different from that of other states. Kansas tracks its individual progress on up to ten unique State performance measures and Kansas tracks its progress on all national performance measures. Kansas compares its performance with the performance of other states using the Maternal and Child Health Bureau's Title V Information System.

Accountability in BFH programs is determined in three ways: (1) by measuring the progress towards successful achievement of each individual performance measure; (2) by budgeting and expending dollars in each of the four recognized MCH services: direct health care, enabling services, population-based activities, and infrastructure-building activities; and (3) by having a positive impact on the outcome measures.

While improvement in outcome measures is the long-term goal, more immediate success may be realized by positive impact on the performance measures. These are measures of short term and intermediate term change, and they are precursors of long term change in outcome measures. It is important to note the change in performance measures because there may be other significant factors outside BFH control affecting the outcomes.

B. State Priorities

The Kansas comprehensive needs assessment, MCH 2015, was completed in 2009-2010. In all, ten priority needs were identified, four for pregnant women and infants and three each for children and adolescents and children/youth with special health care needs.

These are the resulting goals for each population group and the ten Kansas priority needs for 2011-2015:

Pregnant Women and Infants
Goal: Enhance the health of Kansas women and infants across the lifespan.
- All women receive early and comprehensive care before, during and after pregnancy
- Improve mental health and behavioral health of pregnant women and new mothers
- Reduce preterm births (including low birth weight and infant mortality)
- Increase initiation, duration and exclusivity of breastfeeding

Children and Adolescents
Goal: Enhance the health of Kansas children and adolescents across the lifespan.
- All children and youth receive health care through medical homes
- Reduce child and adolescent risk behaviors relating to alcohol, tobacco and other drugs (ATOD)
- All children and youth achieve and maintain healthy weight

Children and Youth with Special Health Care Needs (CYSHCN)
Goal: Enhance the health of all Kansas children and youth with special health care needs across the lifespan.
- All CYSHCN receive coordinated, comprehensive care within a medical home
- Improve the capacity of YSHCN to achieve maximum potential in all aspects of adult life, including appropriate health care, meaningful work, and self-determined independence
- Financing for CYSHCN services minimizes financial hardship for their families

This narrative will describe each priority need, Kansas capacity and resources to address each need, and relation of each to the national and state performance measures.

PREGNANT WOMEN AND INFANTS

1. Kansas women need early and comprehensive health care before, during and after pregnancy.

This priority need was originally selected for MCH 2010 based on state and regional Perinatal Periods of Risk (PPOR) analysis. PPOR was used as a tool to identify excess mortality and to suggest reasons for excess mortality. It suggested which community interventions were most likely to result in improved health outcomes. Kansas data pointed to a need to target the area of Maternal Health/Prematurity and corresponding preconception health, health behaviors, and perinatal care.

MCH 2015 needs assessment stakeholders reviewed the data and concluded that more needs to be done in this area. MCH needs to redirect resources to health education and health promotion activities at both the state and local levels. In addition, through partnerships with stakeholders such as private physicians, March of Dimes, Medicaid, other programs, MCH can help guide policy decision-making relating to health care reform and coordinates public health efforts in support of positive changes in the health care system.

NPMs 8, 15, 18 and NOMs 1, 2, and 3 relate to this priority need.

2. The mental health and behavioral health needs of pregnant women and new mothers should be addressed.

This priority need was selected based on data showing that Kansas women have higher than average rates of cigarette smoking and other stress-related behaviors before, during and after pregnancy. Information needs to be readily available to the public and to women about the value of early/comprehensive health care for women of reproductive age and assimilated. There is a need to change the approach to women's health to a lifecourse perspective.

NPMs 8, 15, 18 and NOMs 1, 2, 3 relate to this priority need.

3. Kansas preterm births, low birthweight and infant mortality should be reduced.

This priority need was selected based on data that show continuing high rates of preterm birth, low birthweight and infant mortality for Kansas. MCH 2015 stakeholders concurred that all three are important and were unable to select from among the three.

Kansas has the capacity to address this priority through prenatal smoking cessation, improved nutritional status, and community-based prenatal case management and care coordination for low-income and high risk women. As well, through its wide array of stakeholder groups MCH can mobilize advocacy for policy changes needed to improve outcomes.

NPMs 8, 15, 18 and NOMs 1-3 relate to this priority.

4. Kansas women need support to increase initiation, duration, and exclusivity of breastfeeding.

The positive benefits of breastfeeding both for the mother and infant are provided in the discussions for NPM 11 and SPM 3. Kansas capacity to address this priority is significant due to partnerships forged across programs including WIC and women's health, due to the low cost of interventions and high yield in health benefits, and finally, due to a change in public attitudes and policy supporting breastfeeding mothers in the community and in the workplace. Kansas has devoted resources to peer education, health promotion and health education efforts, plus public information and education to address this priority.

NPMs 11, 15 and NOMs 1-3 relate to this priority.

CHILDREN AND ADOLESCENTS

5. All Kansas children and youth should receive health care through medical homes

This priority was held over from the last five year needs assessment due to data showing that the number of uninsured children is rising and that the problem of underinsured may be greater than uninsured. There was concern that more needs to be done in this area with the advent of national health care reform. MCH is in a unique position to support families and providers. MCH needs to engage in activities to educate families about the importance of care within a medical home. MCH needs to enlist the support of community partners to increase enrollment in Medicaid and Health/Wave for eligible children.

NPMs 7, 13, and 14 and NOMs 1 and 2 relate to this priority.

6. Child and adolescent risk behaviors relating to alcohol, tobacco, and other drugs should be reduced.

Youth Risk Behavior trend data show that Kansas youth continue to report higher than average use of alcohol, tobacco and other drugs. These priority health risk behaviors are major contributors to morbidity and mortality trends including motor vehicle crashes, unintended pregnancy, HIV/STDs, and other. More effective school health programs and other policy and programmatic interventions are needed to reduce risk and improve health outcomes among youth. In particular, the state needs an Adolescent Health Plan that focuses on the needs of

youth from a health perspective. MCH has the capacity to convene a group of stakeholders to address this need.

NPM 10, 16, and NOM 6 relate to this priority need.

7. Kansas children and youth need to achieve and maintain healthy weights.

This priority will be continued from MCH 2010. There is an increasing trend toward overweight even among very young Kansans and there is a strong association between overweight and health status. Many current efforts in the state focus on the needs of school-age and adult nutrition and physical activity. Kansas MCH not only joins in those efforts but also is in position through its public/private partnerships especially in the early childhood areas to address this priority. The Kansas breastfeeding priority also relates to this priority since breastfeeding has been linked with healthy weight in childhood.

NPMs 11 and 14 relate to this priority.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

8. All CYSHCN should receive coordinated, comprehensive care within a medical home.

This state performance measure holds for all children but in particular for CSHCN. Kansas capacity in this area is expanding to include development of data collection (new application form and survey systems), tracking systems (new CSHCN data system linked to Immunization Registry), parent/provider education about the medical home concept and practice, and linkages to other programs (Newborn Hearing Screening Learning Collaborative).

NPM 3 relates to this Kansas priority although NPM3 is broader and encompasses two concepts: family partnering in decision-making and care within a medical home. Kansas is developing interventions to address both and is developing capacity to track progress.

9. Kansas CYSHCN need early transition planning and services necessary to achieve maximum potential in all aspects of adult life, including health care, work and independence.

Kansas capacity in this area has improved considerably with the realignment of staff duties to include a focus on transition systems. This has resulted in new and enhanced partnerships with organizations in the disability community and a refocusing of state efforts on the needs of youth with special health care needs (YSHCN) as they transition to adult medical care.

NPMs 2-6 relate to this state priority.

10. Financing for CYSHCN services should minimize financial hardship for their families.

Kansas capacity in this area is enhanced through close working relationships with public programs (such as WIC and Farmworker Health) and public insurance (Medicaid and SCHIP). Direct financing of services through CYSHCN dollars has become more restrictive due to dwindling state and federal dollars and rising costs. Hospitals, labs and private providers continue to work with CYSHCN despite reductions in amount of coverage available. Private insurance coverage may only partially offset financial burden to the family or not at all. Rising numbers of uninsured and underinsured add to the ongoing challenge for the program. CYSHCN continues to engage in policy decisions to ration limited dollars.

NPMs 2-6 relate to this State of Kansas priority.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	52	50	45	61	61
Denominator	52	50	45	61	61
Data Source				Kansas Newborn Screening data	Kansas Newborn Screening data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
DATASOURCE:
*NOTE: Data for 2009 is not available at the time of this application. 2008 data was used to pre-populate this peformance measure.

Notes - 2008
DATA SOURCE:
KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2008 .

Notes - 2007
DATA SOURCE: KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2007 .

a. Last Year's Accomplishments
Direct Services:

Medical consultation for children with genetic/metabolic conditions was available statewide through the CYSHCN contractual process. CYSHCN purchased metabolic formula and food products for individuals with phenylketonuria (PKU) and Maple Syrup Urine Disease (MSUD) along with treatment products for conditions identified through the newborn screening (NBS) program. CSYHCN implemented a sliding fee scale for use with all families with children identified through the NBS process including those with cystic fibrosis.

Enabling Services:

KDHE mailed information to parents of infants with congenital anomalies, low Apgar scores, and

low birth weights informing them about services available including: CYSHCN, Part C, Oral Health, WIC and immunizations.

Population Based Services:

Kansas hospital personnel collected blood spot specimens from infants, usually between 24 to 48 hours of age. Specimens were sent by hospital staff to the State public health laboratory for processing. Lab staff notified the NBS follow-up program of abnormal screening results. The NBS program notified the primary care physician (PCP) of the screening test results. Also, the PCP was informed of consultation and referrals available through the CYSHCN program. If the infant is not patient in a neonatal intensive care unit, parents were notified by letter of the need for follow-up with the PCP regarding abnormal screening results. The PCP listed on the blood spot card is reported in the letter to the families. The family is asked to notify the follow-up program if the PCP listed is not their PCP. The NBS follow-up program provided case management services to assure that all infants had appropriate testing, diagnosis, referral and treatment services to the point of diagnosis.

Infrastructure Building Services:

KDHE successfully implemented expansion of the NBS testing to include the core panel of 29 conditions recommended by the American College of Medical Genetics (ACMG). The Kansas Advisory Council continued to guide the implementation and evaluation process and met on a quarterly basis.

Staff from the NBS follow-up program met with laboratory staff on a regular basis in order to coordinate activities and troubleshoot issues. Staff from the public health laboratory and NBS follow-up continued training on specific issues including testing for cystic fibrosis and MS/MS testing.

The NBS webpage on the KDHE website contained the practitioner's manual along with information for families and physicians. The webpage was updated as procedures/letters were modified.

The webpage section "Information for Parents" was translated to Spanish and posted to the website. Parent letters and information sheets were also translated and used with parent mailings regarding abnormal or unsatisfactory specimens.

NBS follow-up staff worked with laboratory, vital statistics and information systems staff within KDHE to enhance our data linkages. The current data system did not include a method to verify that each infant in the state receives a newborn screen. A common data system was needed to track information.

Staff continued to monitor unsatisfactory rates for NBS specimens in the state. Contacts were identified at various hospitals with resulting decrease in satisfactory rates at those facilities. NBS staff followed-up with physicians and parents of infants with unsatisfactory newborn screening specimens to assure that babies return for needed repeat specimens as soon as possible.

MCH contracted with DNAXPRT, Inc. to begin development of a Kansas State Genetics Plan. Plans from various states were reviewed and a draft plan was developed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide nursing case management to families that have infants with abnormal newborn screens.		X		

2. Assure that contracts provide statewide coverage for consultations on NBS conditions.				X
3. Purchase and distribute treatment products to eligible individuals.	X			
4. Arrange transportation, as needed, for follow-up services.		X		
5. Manage data collection and reporting systems for NBS follow-up and birth defects information.				X
6. Provide information to policy makers on MS/MS laboratory and follow-up procedures.				X
7. Notify parents and medical providers about abnormal lab results and follow-up recommendations		X		
8. Provide educations materials such as pamphlets, handouts, DVD and website address to parents and medical providers.		X		
9. Participate in the Newborn Screening Advisory Committee to include QA activities.			X	
10.				

b. Current Activities
Direct Services:

NBS follow-up and CYSHCN staff work cooperatively to assure diagnostic testing is available for patients identified by the NBS program.

Enabling Services:

Due to the re-engineering of the Birth Defects Registry, postcards informing parents of services have been delayed.

Population Based Services:

Continue current services.

Infrastructure Building Services:

This year stakeholders have had two face-to-face meetings and numerous conference calls to finalize the Kansas State Genetic Plan. This plan is being funded through a contract from Heartland Genetics and NBS Collaborative.
The procedure manual will be updated as necessary.

NBS follow-up staff will continue to play active roles in Heartland serving on board and committees.

A new birth defects registry was developed that interfaces with the CYSHCN and NBS data systems. The data bases no longer interface with the State Immunization Registry. Vital Statistics exports birth certificate data into the Birth Defects Registry. The registry continues to receive and monitor legislatively-mandated reports submitted by hospitals, birthing centers, and physicians regarding children under age 5 with a primary diagnosis of congenital anomalies.

A contract has been initiated with Envisage, Inc. to develop a business plan for NBS data systems. The assessment includes the lab information management system (LIMS), the follow-up database and conversations with stakeholders.

c. Plan for the Coming Year

Direct Services:

Continue last year's activities.

Enabling Services:

Continue last year's activities.

Population Based Services:

Continue last year's activities.

Infrastructure Building Services:

NBS follow-up staff will continue to coordinateacttivities through regular meetings with the State public health laboratory staff. Quarterly meetings of the legislatively-mandated, NBS Advisory Council will continue to ensure coordination between the public and private sectors, to evaluate the program, and to consider addition of new tests. The NBS Advisory Council will consider addition of new conditions to the Kansas such as SCID to the screening panel.

The Kansas State Genetics plan will be finalized, monitored and distributed to appropriate persons.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**42566**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	42566	100.0	39	4	4	100.0
Congenital Hypothyroidism (Classical)	42566	100.0	45	31	31	100.0
Galactosemia (Classical)	42566	100.0	22	2	2	100.0
Sickle Cell Disease	42566	100.0	15	14	14	100.0
Biotinidase Deficiency	42566	100.0	8	1	1	100.0
Cystic Fibrosis	42566	100.0	81	7	7	100.0
Homocystinuria	42566	100.0	5	0	0	
Maple Syrup	42566	100.0	1	0	0	

Urine Disease						
Tyrosinemia Type I	42566	100.0	1	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	42566	100.0	1	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	42566	100.0	57	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	42566	100.0	6	0	0	
S-Beta Thalassemia	42566	100.0	2	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	70	70
Annual Indicator	65.6	65.6	65.6	65.6	65.6
Numerator					
Denominator					
Data Source				National CSHCN 2005-2006. Estimate KS.	National CSHCN 2005-2006. Estimate KS.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	67	68	68	69	70

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. The wording of the two questions used to evaluate this outcome remained the same

between 2001 and 2005-2006 National Children with Special Health Care Needs Survey and are therefore, comparable.

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. The wording of the two questions used to evaluate this outcome remained the same between 2001 and 2005-2006 National Children with Special Health Care Needs Survey and are therefore, comparable.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. The wording of the two questions used to evaluate this outcome did not change; same as 2001. Indicator is comparable across survey years.

a. Last Year's Accomplishments
Direct Services:

Completed survey of families who use the CYSHCN-sponsored clinics regarding satisfaction, family/professional partnership in health care decisions, and transition planning/readiness. Clinic staff continued to review concerns with families and make appropriate referrals.

Enabling Services:

Provided and organized information in a meaningful way to enhance the family's role within the health care team. CYSHCN staff coordinated health care plans with family members. Bilingual staff were hired to directly assist Spanish speaking families but there is phone support for translation services when needed.

Population Based Services:

The objective to engage the early intervention team and hosptial discharge planners to determine how to engage families at time of diagnosis was put on hold due to staffing changes and other priorities.

Infrastructure Building Services:

The Parent Advisory Committee was reactivated under new section director's leadership and vision.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CYSHCN staff meet with families at each multi-disciplinary clinic visit to assess and address family needs	X			
2. Treatment plans are reviewed with youth and family to assure understanding and agreement.		X		
3. Families identify and choose primary service providers	X			

4. MCH toll-free line has multi-lingual interpreter access.		X		
5. Families serve on a Parent Advisory Committee			X	
6. Families and youth are financially supported to serve on CYSHCN advisory committee.			X	
7. Educational materials promote family/professional partnerships.			X	X
8. Personal health care notebooks and training on how to use are available from Families Together, Inc.			X	X
9. Assurance of bilingual services in clinics and when families talk with CYSHCN staff.		X		
10. Youth, family members and professionals serve on the D-70 grant advisory council and are included in the Learning Collaborative in Washington, D.C.			X	X

b. Current Activities
Direct Services:

Family Advisory members are paid a stipend and reimbursed for travel in order to attend council meetings. CYSHCN health care plans are renewed annually with family input sought. There will be family representation at the June 2010 D-70 meeting in Washington, DC.

Enabling Services:

Networking is encouraged through emails. Advisory meetings are scheduled around the families' schedules. A copy of specialty clinic evaluation and recommendations are provided to families and primary care providers. Family survey outcomes were conducted in FY 09 published in the CYSHCN magazine and on the CYSHCN website.

Population Based Services:

Conducted 8 regional town hall meetings. Published CYSHCN magazine that is available in English and Spanish. Data from 2008 KS Youth Survey and the 2009 Family Survey are used for the 5-year needs assessment. D-70 grant engages three family members who also serve on the CYSHCN Parent Advisory Council enabling more comprehensive and coordinated focus between the two projects. Due to change in Part C (Infant-Toddler Early Intervention) team gains were not made in targeting hospital discharge teams to assist families in obtaining discharge summaries, initiating setting up personal health history/care notes books.

Infrastructure Building Services:

Adopted Advisory Council charter and by-laws; member contact information posted on website; minutes posted after review by members.

c. Plan for the Coming Year
Direct Services:

CYSHCN will provide financial support to family/youth advisory members and support for family representation to AMCHP.

Enabling Services:

Youth involvement will be expanded through development of a youth advisory council. Through the youth advisory council, they will gain leadership and self-advocacy skills, provide feedback and "youth voice" to CYSHCN program activities, and promote successful transition. Using D-70 funds, an on-line transition curriculum will be developed to empower youth to take more active

roles in managing their health care needs and advocate for services to achieve their individual goals.

Continue work with family disability organizations to increase family voices in CYSHCN policy and practice.

Population Based Services:

CYSHCN will make available materials in requested languages and alternative formats. Continue annual town hall meetings or listening tours will be continued providing sign language and interpreters for requested languages. Promote these meetings in multiple regions to hear various cultural perspectives and needs.

Infrastructure Building Services:

CYSHCN will support family involvement in advisory council meetings, learning collaborative and other special projects. Ongoing discussions and dialogs will be initiated to encourage providers to engage family "coaches" or "navigators" within their practices. Consumers will be referred to Partners in Policy Making trainings.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	60	60	60	60
Annual Indicator	55.3	55.3	55.3	55.3	55.3
Numerator					
Denominator					
Data Source				National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	60	60	60

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. Substantial additions, wording changes, and skip revisions between 2001 and 2005-

2006 National Children with Special Health Care Needs Survey have occurred. This indicator is not comparable with pre 2005 data.

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. Substantial additions, wording changes, and skip revisions between 2001 and 2005-2006 National Children with Special Health Care Needs Survey have occurred. This indicator is not comparable with pre 2005 data.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Substantial additions, wording changes, and skip pattern revisions were made in 2005-06 to the sets of questions used to construct the Care Coordination and Access to Referrals components of the medical home composite measure for this outcome. Indicator is not comparable across survey years.

a. Last Year's Accomplishments
Direct Services:

Contracts required that specialty evaluations and recommendations were sent to the primary care provider within 2 weeks after appointments. The postcards generated from the birth defect registry were discontinued in December 2008 due to a low return rate and information that families were being referred to medical homes and community services at time of discharge.

Enabling Services:

Breakout sessions at family organizations were conducted to educate and build family and young adult's skills to be effective in partnering with providers and to assume a more active responsibility for their "life choices" and health care. Articles addressing families and youth empowerment and how to engage youth in decision making were included in the CYSHCN Magazine available in clinic waiting rooms and for distribuation at conferences and through partnerships.

Population Based Services:

Many CYSHCN brochures, websites and other materials were available in English and Spanish. Alternative formats and languages were accomodated upon request.

Infrastructure Building Services:

CYSHCN participated in the state-level, multi-agency Medical Home Initiative. Family/youth/professional partnerships and increasing access and services received within a Medical Home were two grant objectives of the HRSA D-70 Integrated Community Systems for Youth with Special Health Care Needs grant awarded to Kansas in June 2009. Grant and program efforts were supportive of coordination and collaboration with other programs who have Medical Home initiatives.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical specialty reports are provided to the PCP and other providers identified by the family.	X			
2. CYSCHN authorizes follow-up services within the medical home related to the eligible health conditions.	X			
3. Contracting PCP can access the state-wide immunization registry.				X
4. CYSHCN tracks medical home status of clients seen in specialty clinics and assists families to obtain a PCP.		X		
5. Infants identified with a positive newborn screening test are referred to CYSHCN program. Access to follow-up services are explained to families.		X	X	
6. Goals of the D-70 grant include: addressing access to and services received within a medical home, strengthening youth/family/professional partnerships, and supporting health care transition planning within the medical home.			X	X
7. Develop informational materials; promote full inclusion of the medical home elements while HIT/HET are being implemented.				X
8.				
9.				
10.				

b. Current Activities
Direct Services:

Same as 2009. Outcome data from the family and physician survey is shared with providers in open dialog on how to better coordinate services between primary and specialty clinics.

Enabling Services:

The states' Medical Home Initiative lead by the Kansas Health Policy Authority was given a lower priority due to budget cutbacks in July 2009. The CYSHCN program, through the HRSA D-70 Integrated Community Systems grant, reinvigorates interest in the Medical Home Initiative and assumes a greater leadership role in identifying champions and networking with other programs with medical home efforts and goals.

Population Based Services:

A recent collaboration with the Heartland Genetics Collaborative and other D-70 grantees to develop a regional workgroup who will work to improve transition within the Medical Home for youth with metabolic conditions. Some of the projected outcomes of this group include developing a "model" for transition within a Medical Home and hosting a multi-state learning event that supports the defragmentation of systems and policies.

Infrastructure Building Services:

CYSHCN strengthens relationships established through the FY 09 State Medical Home initiative & to address concerns associated with establishing a Medical Home (impact change on the business model, needed technology, training for both providers and families, etc) continue. Through the D-70 grant, a funding opportunity encourages pilot projects addressing medical home access.

c. Plan for the Coming Year
Direct Services:

Will work with family and youth organizations to develop youth training modules through the D-70 Integrated Community Systems grant on how to partner and communicate with their doctor. CYSHCN will continue contracts with providers for primary and follow up care that can be provided in local communities. CYSHCN clinic staff will continue to assure that specialty clinic notes are sent to the primary care providers within two weeks of the appointment date after receiving parental approval.

Enabling Services:

Will expand program and grant e-mail listservs to share effective practices models and promote collaboration and integration of health into partner's programs and activities. Support will be provided at family and provider conferences through speakers and presentations. As a contractor with the D-70 grant, the KU Center on Developmental Disabilities will conduct guest lectures to medical and nursing students.

CSHCN will collaborate with F2F grantee to empower families to take more active roles as partners with their health care providers. Contracts will support communication between primary and specialty providers to coordinate care.

Population Based Services:

CYSHCN will incorporate known regional and ethnic data regarding health care access and outcomes in policy and practice changes. Community brokers will be used to enhance care coordination and address language barriers.

Infrastructure Building Services:

Through collaboration with Heartland, CYSHCN and the D-70 grant will present at the Heartland Genetic Fall Conference on Kansas activities to promote medical home transition. Continue to network with medical home "champions" and continue to move Kansas medical home initiative forward within CYSHCN's capacity.

CYSHCN and D-70 staff are lead agents in the Genetic Transition Taskforce to develop a"model" for youth with metabolic conditions. Utilize effective tools already developed to use with the "model" (planning started in February 2010).

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	64	64
Annual Indicator	62.9	62.9	62.9	62.9	62.9
Numerator					
Denominator					
Data Source				National CSCHN 2005-2006. Estimate KS	National CSCHN 2005-2006. Estimate KS

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	64	68	68	68	68

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. Indicators are comparable because no changes have occurred between 2001 and 2005-2006 National Children with Special Health Care Needs Survey.

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. Indicators are comparable because no changes have occurred between 2001 and 2005-2006 National Children with Special Health Care Needs Survey.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Indicator is comparable across survey years (no changes; same as 2001).

a. Last Year's Accomplishments
Direct Services:

Age eligibility for CYSHCN was changed to age 22. With the expansion of the Newborn Screening Program, adults with eligible genetic conditions were seen in CYSCHN-supported specialty clinics and some qualified for financial assistance.

Enabling Services:

State applications were available to download and complete. The Medicaid Clearinghouse liaison worked with the CYSHCN program to resolve benefit concerns. Individuals were directed to safety-net clinics if other options were not available. The Kansas Equipment Exchange Program provided a means to return outgrown, no longer needed durable medical equipment and recycled it for other children to use, saving insurance benefits to be used later and assuring the equipment met the child's needs when a major purchase needed to be made.

Population Based Services:

Kansas insurance coverage rates declined due to job losses. Uninsured individuals were directed to state programs for eligibility determination and financial assistance.

Infrastructure Building Services:

Healthwave coverage and Health Care Reform advocacy with the legislature was the key activity of our stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor Federal and State leadership efforts to provide affordable health care coverage.				X
2. Educate families and providers on specific elements of the Health Care Reform Bill that may impact access to services, and coverage.				X
3. Coordinate with SCHIP/Medicaid on eligibility determinations.		X		
4. Route metabolic formula orders through CYSHCN for discounted rate to reduce out of pocket expenses.		X		
5. Authorize eligible services with contracted providers that take CYSHCN's negotiated rates to avoid/minimize family's liability.		X		
6. Coordinate with private non-profit organization to fund medically necessary treatments and equipment not otherwise covered.		X	X	
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services:

Individuals are redirected to apply for reauthorized public insurance. CYSHCN continues to authorize and fund specialty care for eligible children 0-22 and eligible adults with genetic conditions.

Enabling Services:

CYSHCN assists families to maximize available funding sources and effectively use alternative options to secure necessary durable medical equipment. Kansas Association for the Medical Underserved (KAMU) along with Oral Health Kansas conducts free dental clinics several times per year in different geographic locations using volunteer dental providers.

Population Based Services:

Job layoffs and loss of insurance coverage are taxing CYSHCN resources, particularly for certain minority populations. Safety-net clinics are seeing a substantial increase in clients.

Infrastructure Building Services:

CYSHCN is providing funds to medical providers and family partners to educate families and young adults about components of the Health Care Reform Bill (physical and mental health) that

may impact their ability to regain, keep or expand current insurance options.

c. Plan for the Coming Year
Direct Services:

CYSCHN clinic staff will review insurance status and assist families to apply for eligible benefits. CYSCHN continues to be the sole source of specialty care for eligible uninsurable persons.

Enabling Services:

The importance of preventive services and wellness maintenance will be integrated into program educational activities. Information about the impact of the Health Care Reform Bill will be shared with families and providers.

Population Based Services:

Competency training and how to craft culturally and linguistically appropriate messages to minority populations will continue.

Infrastructure Building Services:

Federal and state health care reform implementation will be monitored. Families and providers will have access to reliable information. Links to information will be posted on CYSHCN and partners' websites, in newsletters and in flyers.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	95	95
Annual Indicator	92.5	92.5	92.5	92.5	92.5
Numerator					
Denominator					
Data Source				National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99	99	99	99	99

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. Significant changes have occurred between 2001 and 2005-2006 National Children with Special Health Care Needs Survey in placement, phrasing, and ordering of this question. Thus, this indicator is not comparable with pre 2005 data.

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. Significant changes have occurred between 2001 and 2005-2006 National Children with Special Health Care Needs Survey in placement, phrasing, and ordering of this question. Thus, this indicator is not comparable with pre 2005 data.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. Significant revisions were made to the wording, ordering and placement of the question in the 2005-06 survey. Indicator is not comparable across survey years.

a. Last Year's Accomplishments
Direct Services:

CYSHCN financially supported outreach specialty clinics in seven regions of the state. Multi-disciplinary clinics were provided when school districts requested evaluations and collaboration on treatment supports.

Enabling Services:

Interpretation services were provided to families. If travel over 50 miles was required, CYSHCN would reimburse families whose requested travel assistance support prior to the appointment where the service would be needed.

Population Based Services:

The Kansas Early Intervention Program ("tiny-k") continued to provide services in a natural setting (home, child care center, etc.) and collaborated with the CYSHCN program for eligible services. CYSHCN provided follow-up screenings for Sound Beginnings (the hearing screening program) and accepted referrals for on-going follow up on positive newborn screening tests.

Infrastructure Building Services:

CYSHCN participated on the Oral Health, Sound Beginnings, EPSDT, and the Newborn Screening Advisory Councils and regularly attended meetings for the Early Child Care and Early Education programs, the Kansas Commission on Developmental Concerns, and the Kansas

Council on Developmental Disabilities to assure that CYSHCN efforts are complimentary to those of other programs working with the same target populations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Special needs outreach clinics are held in underserved areas of the state.		X	X	
2. CSHCN (age 0-3) are referred to Part C Early Intervention networks the serve their community.		X		
3. Special Child Care Clinics are offered in local communities through an interagency agreement with the Kansas State Department of Education.		X	X	
4. Interpreter services are covered for visits with local and specialty providers as needed.	X	X		
5. Transportation support is provided via EPSDT benefits or are authorized by CYSHCN if over 50 miles one way.		X		
6. CYSHCN staff work with locals to identify ongoing needs, coordination of services and resources.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services:

Individuals are redirected to apply for reauthorized Public Insurance. CYSHCN continues to authorize and fund specialty care for eligible children 0-22 and eligible adults with genetic conditions.

Enabling Services:

Through the D-70 Integrated Community Systems grant, eight regional town hall meetings were conducted to identify consumer needs, barriers, gaps and best practices regarding transition and medical home partnerships for youth with special health care needs. A common theme among all meetings included a lack of knowledge about resources. A primary request from consumers (and even professionals) was for a central access point to find resources and information to assist with navigating the various systems. Efforts to develop a state and local resource guide will begin summer 2010.

Population Based Services:

Due to regional access, families continue to drive long distances for primary, specialty, dental and mental health care.

Infrastructure Building Services:

Through the regional meetings and listening tour, there has been an opportunity for consumers, community leaders, service delivery progessionals and medical providers to meet and share their concerns. Solutions were formatted to address some issues while others will require more capacity to implement.

c. Plan for the Coming Year
Direct Services:

Local resources are identified in the annual CYSHCN generated health care plan and is provided with community resources to families, primary care providers and authorized service providers. Telemedicine technology is expanding as access capacity and internet compatibility becomes available in rural areas of Kansas. Specialty outreach clinics are supported through CYSHCN contracts and a discussion to expand these clinics is under review contigent on provider availability, technology capacity and funding.

Enabling Services:

Providers and consumers are directed to local and regional resources through the Make A Difference Toll Free telephone line and Website, as well as United Way 2-1-1. Through the D-70 grant, an intern will be hired to assist in compiling multiple registries into a community/regional friendly toolkit accessible to consumers and providers.

Population Based Services:

Ethnic and cultural resources will be included in the resource guide and information will be provided in other languages and formats upon request.

Infrastructure Building Services:

CYSHCN and the D-70 grant plans to continue the regional meetings possibly hosting workshops in each region and to further strengthen contacts made in 2010. These meetings or workshops will provide opportunities for participants to share ideas and support integration among various regions. Ongoing maintenance of the resource directory will support sustainability of the D-70 project efforts and promote integration and collaboration from various agencies and stand-alone organizations that have developed limited resource directories.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	6.3	6.3	53	53
Annual Indicator	50.3	50.3	50.3	50.3	50.3
Numerator					
Denominator					
Data Source				National CSHCN 2005-2006. Estimate KS	National CSHCN 2005-2006. Estimate KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	55	55

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. Substantial alterations, additions, and difference in skip pattern have occurred between 2001 and 2005-2006 National Children with Special Health Care in these questions. Thus, this indicator is not comparable with pre 2005 data.

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. Substantial alterations, additions, and difference in skip pattern have occurred between 2001 and 2005-2006 National Children with Special Health Care in these questions. Thus, this indicator is not comparable with pre 2005 data.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

a. Last Year's Accomplishments
Direct Services:

Specialty clinics conducted transition clinics for older youth with special health care needs. Trainings began through the F2F grants (Families Together, Inc.) focusing on teaching participants about the use of a personal health care notebook.

Enabling Services:

Families were referred to resources and organizations to determine appropriate levels of guardian support that may be needed for youth with special health care needs. Participation in resource fairs provided opportunities to learn and share community connections to assist in transitioning not only to adult health care providers, but to address other aspects of work and community living.

Population Based Services:

Contracts with education and family support organizations resulted in regional transition conferences to educate and inform parents and families about necessary steps for successful transitions. CYSHCN staff participated as attendees, exhibitors and speakers.

Infrastructure Building Services:

Contract language was strengthened to outline transition planning performance measures in all vendor contracts. CYSHCN continuer to serve on advisory councils that addressed youth issues and disability concerns.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition clinics for Cystic Fibrosis, Cerebral Palsy, Cleft Lip/Palate and Spinal Cord are held regularly for the older youth.	X	X		
2. Coordinate with family and education partners' transition workshops.			X	X
3. CYSHCN staff participate in local, regional, state and national workshops to promote inclusion and increase awareness of the needs of YSHCN.				X
4. Goal for the D-70 grant to address transition to adulthood, with a focus on health care and health management, by incorporating transition supports for youth and young adults with special health care needs.			X	X
5. CYSHCN staff represents the Secretary of KDHE on the Kansas Commission on Disability Concerns, Kansas Autism Commission, and Kansas Council on Developmental Disabilities.				X
6. Transition information and personal care notebooks are shared with families and providers to support transition planning.		X	X	
7. Family/parent advisory council provides feedback and guidance on current and future transition efforts.			X	X
8.				
9.				
10.				

b. Current Activities
Direct Services:

The Cleft Lip/Palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord Clinics continue to schedule transition clinics. Adults with eligible genetic conditions are seen in adult specialty clinics.

Enabling Services:

Data from NSCSHCN 2005-06 was shared with multiple agencies supporting transition services. An advisory council for the D-70 Integrated Community Systems grant was developed and includes parents and youth, representatives from education, disability employment navigators, rehabilitation services, pediatric and adult health, oral and mental health, and family and youth advocacy groups. Advisory group training sessions have provided a broad view of transition issues and encourage stakeholders to think "outside the box" to find opportunities to collaborate.

Population Based Services:

CYSHCN staff serve on the Shared Vision for Youth council. Data shows an average of 81-85% of KS youth with an IEP were employed or received higher education one year after graduation. The D-70 grant sponsored four youth to attend the Youth Empowerment Academy's week long Youth Leadership Forum. A computer-based curriculum is being developed to promote self-determination and provide opportunities to learn, practice and master skills necessary for

successful transitions. An emphasis will be place on health and wellness, but will also include all aspects of adult life. Supportive technology will be utilized to empower youth to understand and manage health care needs.

c. Plan for the Coming Year
Direct Services:

Through partnerships with CYSHCN and the D-70 grant, Families Together, Inc. (F2F grantee) will host regional workshops for youth and families on all aspects of transition. Health and wellness management that emphasizes personal responsibility will be integrated into these transition workshops and conferences. CYSHCN will continue to support and promote the use of personal health history notebooks, which include sections to help families organize health information such as: health history, emergency preparedness, transition planning and goal setting for adulthood, selecting an adult health care provider, and much more.

Enabling Services:

A regional and state-wide resource tool kit and navigational guide to assist youth, family and providers connect to community/regional resources will be developed and disseminated. Furthermore, efforts to update the MADIN resource base will continue.

Population Based Services:

The computerized curriculum on self-determination and transition planning will be piloted within school systems. The curriculum will pilot the health module curriculum first and then will be expanded with the addition of modules for education, employment, and independent living. A Youth Advisory Council is being developed to provide the "youth voice" to the D-70 grant project and CYSHCN program. Youth members will be given opportunities to attend various leadership and advocacy skill building trainings, work with other youth their age (both locally and across the state), and to participate in a variety of meetings (all voluntary) about specific issues or topics. Youth will be asked to share their experiences and ideas and to help us understand what is needed to make it a better and smoother transition process for youth and their families.

Infrastructure Building Services:

Continued discussion about common priorities - duplication of efforts; gaps in service delivery; and stronger youth involvement - will support collaborative efforts and integration of systems. Efforts to develop and disseminate materials to families, youth, providers, and partners about key steps towards health care transition and incorporating health into other aspects of transition will continue. Through the self-determination and transition planning curriculum, common technology tools will be used to allow youth increased independence in their health care management.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	82	82	89	90	90
Annual Indicator	87.5	83.6	83.3	76.7	76.7
Numerator					
Denominator					

Data Source				CDC National Immunization Survey 2008--KS	CDC National Immunization Survey 2008--KS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	79	79	80	80	81

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention. National Center for Immunization and Respiratory Diseases. Vaccines and Immunization. US, National Immunization Survey, Q1/2008-Q4/2008. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/08/tab02_antigen_iap.xls

Data for 2009 is not available. 2008 data was used to pre-populate this performance measure.

Note** indicator was changed. Prior to 2008, National Immunization Survey rates for DTP(4): Polio(3):MMR(1) combination were reported. Due to the changes in the National Immunization Survey, data for 2008 reports the rates for DTP(4): Polio(3): MMR(1): Hib (3): HepB (3): Varicella (1) combination. In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age. For school year 2008-2009, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 10.

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention. National Center for Immunization and Respiratory Diseases. Vaccines and Immunization. US, National Immunization Survey, Q1/2008-Q4/2008. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/08/tab02_antigen_iap.xls

Note** indicator was changed. Prior to 2008, National Immunization Survey rates for DTP(4): Polio(3):MMR(1) combination were reported. Due to the changes in the National Immunization Survey, data for 2008 reports the rates for DTP(4): Polio(3): MMR(1): Hib (3): HepB (3): Varicella (1) combination. In Kansas, Haemophilus Influenza type B (HiB) is not required for school entry but is required for public preschools or school operated child care for children under five years of age. For school year 2008-2009, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 10.

Notes - 2007
DATA SOURCE: Centers for Disease Control and Prevention. National Center for Immunization and Respiratory Diseases. Vaccines and Immunization. US, National Immunization Survey, Q1/2007-Q4/2007. Estimated vaccination coverage with individual vaccines and selected vaccination series among children 19-35 months of age by state and local area. Table located on the web at http://www.cdc.gov/vaccines/stats-surv/nis/tables/07/tab02_antigen_iap.xls

National Immunization Survey Rates for DTP4: Polio3:MMR1 combination are reported here. In Kansas, Haemophilus Influenza type B is not required for school entry. For school year 2007-2008, Hepatitis B (3 doses) and varicella (1 dose) are required for all children in kindergarten through grade 3.

a. Last Year's Accomplishments

The Retrospective Immunization Coverage Survey, 2004- 2005 Results (School Year 2008-09), reported statewide coverage rate for the 4-3-1-3-3 series (DTaP4, Polio3, MMR1, Hib3, HepB3) for children by 24 months of age was 63%, which was below the Healthy People 2010 goal of at least 80%. Varicella vaccination, which had been required for school entry since the 2004-05 school years had a coverage rate of 81% by 24 months of age (http://www.kdheks.gov/immunize/download/retrospective_2008-09.pdf).

Kansas was recognized in early 2009 at the National Immunization Conference for having the second highest increase in immunization rates for the 4:3:1:3:3:1 series over a three-year period. Between 2004 and 2007, Kansas showed an 11.3 percent increase in coverage in the 4:3:1:3:3:1 series. Nationally, the average increase was 1.2 percent.

KIP reports "according to the latest 2009 survey conducted by the Kansas Foundation for Medical Care for the Kansas Health Policy Authority (KHPA), immunization rates had increased from 56 to 82.21% for Health Connect Kansas, 48 to 80.66% for Healthwave-19 and 49 to 87.09% for Healthwave-21 children since the project began in 2003."

Immunization requirements for school year 2010-2011 were developed. Hepatitis B (3 doses) and Varicella (2 doses) will be required for children in kindergarten and grade 1 with one dose required grades 2-10 unless history of disease documented by a licensed physician. The following vaccines will be recommended for 12 - 15 month olds by the Kansas Immunization Program (KIP): DTP4: Polio3: MMR1 combination. The Haemophilus Influenza type B, Pneumococcal Conjugate and Hepatitis A will not be required for school entry, but will be required for a child < 5 years of age in early childhood programs operated by a school.

Direct Services:

In April 2009, when the first H1N1 disease incidence was recorded, KDHE had a newly developed untested fully-operational Countermeasure and Response Administration System (KS-CRA). Slight modifications were made allowing for expedited mass data entry and aggregate reporting allowing users to access current patient KSWebIZ demographics/immunization history to enter H1N1 vaccine administration (http://www.kdheks.gov/immunize/webiz_download/May_2010_Newsletter.pdf). This initiative resulted in an increase of 200,000 patients and an increase of 1.3 million vaccinations documented in KSWebIZ since September 2009. Over the five month H1N1 flu vaccine campaign, KIP distributed 893,500 doses of H1N1 compared to all 646,000 VFC vaccine doses for 2009 (http://www.kdheks.gov/immunize/the_buzz/BUZZ_MARCH_2010.pdf).

As of May 2009, 132 private/ 85 public providers were on KSWebIZ with 84 Local Health Departments (LHD) out of 105 counties using KSWebIZ. 70 school districts/151 school nurses used the school module.

Enabling Services:

KIP and KHPA sponsored "Immunize Win A Prize" in which VFC providers sent names of families with timely completion of vaccinations for their children. This statewide campaign provided prizes to hundreds of winners, including a $400 utility bill payment. All Kansas children were eligible but to qualify, children had to receive immunizations from a Vaccines For Children (VFC) provider (http://www.kdheks.gov/immunize/bee_wise.html).

Population Based Services:

KIP began assessing adolescent immunization coverage rates giving clinics a baseline measurement/providing awareness to assess adolescent immunization records during every clinic encounter (http://www.kdheks.gov/immunize/the_buzz/BUZZ_MARCH_2010.pdf). Adolescent/adult vaccine information was provided to public health/school nurses promoting vaccinations to protect infants/young children.

Approximately 700 congratulatory birth cards featuring an immunization schedule/reminder to contact health providers for vaccinations were signed by the Governor and sent to all new parents giving permission to enter for their baby in KSWebIZ.

KAR 28-1-20 was amended to include immunization requirements for children in licensed child care facilities, registered family day care homes/early childhood programs operated by schools providing continuity and a single regulation for immunization requirements.

Infrastructure Building Services:

Maximizing Office-Based Immunizations (MOBI-KS), a joint partnership between the Kansas Chapter of the American Academy of Pediatrics/KIP provided training to physicians at conferences and on-line in an effort to increase private providers administering VFC

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Private and public providers of immunizations will receive technical assistance/consultation on questions regarding immunizations, specific vaccines and vaccine service from the Kansas Immunization Program.		X	X	X
2. The Kansas Immunization Program (KIP) promotes provider partnerships through delegation agreements to administer vaccines to increase and maintain high levels of immunization for all children and adolescents.				X
3. An electronic exchange of information between the Kansas WIC Program (KWIC) and the KSWebIZ allows WIC staff to view a child's immunization records to determine vaccine status with administration of the vaccine on-site or referral to the health care	X	X	X	X
4. Continue expansion and use of KSWebIZ to maintain immunization records in medical homes and school settings utilizing interfaces with other data sources, including Medicaid.		X		X
5. KIP and the Kansas Chapter of the American Academy of Pediatrics promotes Maximizing Office-Based Immunizations (MOBI-KS) and provides training in physician provider offices, a joint partnership between the provided training to physicians at confere			X	X
6. Birthing hospitals will provide birth dose of hepatitis B as VFC provider with 4 Eastern Kansas hospitals/their associated local health departments targeting free Tdap vaccination of postpartum mothers of newborns in the hospital.	X	X	X	X
7. Identify strategies to provide vaccine education to school populations supporting school-based immunization clinics collaborating with medical homes and local health departments.	X		X	X
8. Schools, public and private health agencies will provide education on age-appropriate immunizations to parents at well-		X	X	X

child screening, enrollment into child care/early childhood/school age programs, and other points of parent contact using education				
9.				
10.				

b. Current Activities
Direct Services:

As of May 31, 246 providers (107 LHD/141 private providers) use KSWebIZ.

KIP visited 10 LHD/9 counties in 5 days promoting "Beewise Immunize in Flight" during National Infant Immunization Week. Nearly 68% of all 201, 500 vaccines administered in KSWebIZ were to children <3 years of age.

WIC Program (KWIC)/KSWebIZ allow the electronic exchange of information allowing WIC staff to view a child's immunization records to determine vaccine status.

Enabling Services:

The Governor's Birth Card Project /"Immunize and Win a Prize" continues.

LHD/MCH receives KIP and ZIPS monthly newsletters.

Population Based Services:

In January KIP began the "Cocoon Pilot Program" partnering with 4 Eastern Kansas hospitals/their associated LHD to target free Tdap vaccination of postpartum mothers of newborns in the hospital and one primary family caregiver with the opportunity for Tdap vaccination at the LHD.

Infrastructure Building Services:

MOBI-KS has a new provider grant incentive program. Offices hosting training are eligible to apply for grant funding to help with vaccine administration/storage office purchases or data KSWebIZ entry. Offices completing required follow-up are eligible for additional funding.
323 personnel in 133 school districts (526 schools) use KSWebIZ School Nurse Module with >21,000 children and >140,000 vaccinations added into the system. KIP provides regional trainings with 3 scheduled for the School Nurse Conference. Online training is planned fall 2010.

c. Plan for the Coming Year
This National Performance Measure has been discontinued for SFY 2011.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	19	19	18	18	20
Annual Indicator	19.6	19.5	21.7	22.0	22.0
Numerator	1135	1152	1273	1261	1261
Denominator	57812	59155	58780	57321	57321

Data Source				Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	20	20	20	20

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source:
Numerator = Birth certificate (resident) data, 2008, Bureau of Public Health Informatics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2008

Notes - 2007
Data Source:
Numerator = Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2007

a. Last Year's Accomplishments
In 2008, (the most recent year preliminary national data for this age group is available), the teen birth rate (ages 15-17) was 22.0 per1,000 females. This was 1.4% higher than 2007 (21.7 per 1,000).

There was a decreasing trend over the interval 1999-2005 (24.1 to 19.6 per 1,000 respectively), followed by an increasing trend from 2005-2008 (19.6 to 22.0 per 1,000 respectively). The APC (annual percent change) is significant only for the segment corresponding to 1999-2005.

Chlamydia rates are an indicator of teen sexual activity and pregnancy risk. In 2008, the U.S. chlamydia rate for adolescents ages 15-19 was 1,706 per 100,000. In 2008, the chlamydia rates for all Kansas adolescents' ages 15-19 was 1,355 per 100,000. The rate for all Kansas females ages 15-19 was 2,486 per 100,000; for Hispanic females (15-19) 2,367 per 100,000; and for Black females, 7,867 per 100,000.

Direct Services:

Teen Pregnancy Case Management (TPCM) was provided to support pregnant and parenting adolescents up to age 21 in order to reduce negative pregnancy outcomes and delay future pregnancies. There were 409 total teens in six programs in five counties, 89% did not have a repeat pregnancy. All participants received adequate prenatal care while in the program. All teens kept EPSDT and immunizations up to date on their child(ren) and no teen was in child custody judication.

MCH, Kansas State Department of Education (KSDE) staff, and the Kansas Department of Health and Environment (KDHE) staff attended the National Stakeholders Meeting Reconvene sponsored by CDC-DASH and AMCHP. As a result of this partnership and attendance at the

meeting, a Kansas City (KC) school with high teen pregnancy and STD rates was selected as a pilot to provide an STD clinic on the high school campus.

Enabling Services:

The Kansas Abstinence Education Program (KAEP) funded projects in 9 counties with Section 510 Abstinence Education of Title V funding. However, KDHE chose not to apply for abstinence only funding for SFY 2010.

The KC pilot project school health staff received training in the use of "Reducing the Risk" curricula - a proven effective program to reduce teen pregnancy rates and related negative behavior.

Population Based Services:

Community-Based Teen Pregnancy Reduction Projects were funded at six sites. Projects strived to help teens achieve their full potential using proven curricula and positive youth development strategies. At the end of the second year using this approach, qualitative assessments indicated that knowledge and attitudes of the students changed. Students' pre and post-test scores showed an increase in knowledge and an increase in the value of long-range goal setting.

MCH adolescent health staff collaborates with KSDE and seven states to provide educational conference on HIV/AIDS/STDs. There were 197 participants from 21 states.

MCH continued to partner with KDHE's STD Prevention Program to identify early and treat cases of chlamydia. Disparate populations continues to be the target of teaching and intervention efforts though the schools and health fairs.

Infrastructure Building Services:

The National Stakeholders Meeting Reconvene team continued to receive technical assistance for the pilot project in KC.

MCH staff continued collaboration with the Title X Family Planning staff to assure that contraceptive services and counseling were accessible to teens in all geographic areas across Kansas.

MCH staff provided TA to grantees on grant writing and provided support to secure funding to sustain teen pregnancy prevention efforts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide family planning and STD prevention/treatment services to adolescents.	X	X	X	
2. Continue to develop and promote evidence based teen pregnancy prevention programs using principles		X	X	X
3. Continue work with the Reconvene team on developing a youth advisory council addressing health disparities in STD clinics and support Kansas City School Pilot project.	X	X	X	X
4. Collaborate with Positive Youth Development team to provide training that encourages teen to develop goals and avoid unhealthy decisions.		X	X	X
5. Promote the prevention of Fetal Alcohol Spectrum Disorder (FASD) in teen's children though education and participation in		X		X

FASD prevention campaigns.				
6. Serve on a SRS Kansas Child Welfare Quality Improvement Committee to improve the permanency of teens in the foster care system that are pregnant or parenting.				X
7. Actively look for opportunities to address teen pregnancy disparity issues such as speaking opportunities and program committee involvement.		X	X	X
8. Serve on committee with Social and Rehabilitation Services agency to provide education and support male involvement programs and resources.		X	X	X
9. Plan and participate with Kansas State Department of Education and surrounding states to offer a regional training on HIV/STD/AIDs prevention conference.		X	X	X
10.				

b. Current Activities
Direct Services:

The TPCM projects terminated June, 2009 due to state budget shortfalls.

MCH and Kansas Title X Family Planning (FP) program has contractual relationships with 58 FP agencies located in Kansas focusing on STD screening for all women 24 years of age or younger.

The KDHE STD Section staff report chlamydia rates are increasing because of increased availability of testing and perhaps more disease. The current level of funding for STD treatment is not sufficient for universal partner intervention.

The KSDE/KDHE team continues to develop a youth advisory council to address disparities and peer education within the Kansas City school pilot.

Enabling Services:

MCH partnered with KSDE to provide AIDS/HIV/STD education for teachers and nurses with topics that include the technical world of teen sexuality, current trends in adolescent sexual behavior, HIV prevention for incarcerated youth, and literature's impact on human sexuality.

The KDHE STD Section continues use of MySpace, Facebook, and Twitter providing relevant STD information to teens.

Population Based Services:

KDHE submitted a grant application to fund local communities with information, resources and support to assure comprehensive teen pregnancy prevention education to teens in the school setting.

Infrastructure Building Services:

KDHE continues to partner with KSDE and all departments within KDHE to assure that access to information and resources is maximized.

c. Plan for the Coming Year
Direct Services:

The legislature appropriated funding to provide case management to pregnant and parenting teens to reduce negative pregnancy outcomes and delay future pregnancies. A new RFP for this

program will be developed and opened to new and previous projects.

Enabling Services:

KDHE staff will continue to support evidence based TPP, FP and STD program efforts to reduce teen pregnancy and STDs.

Population Based Services:

If the teen pregnancy prevention grant is awarded to KDHE, evidence-based curricula will be initiated in targeted middle and high schools.

MCH will continue collaboration with KSDE to provide training on adolescent health issues and continue to provide school nurse/MCH education.

KDHE staff will provide Fetal Alcohol Spectrum Disorder (FASD) training to teens and groups that work with teens to prevent FASD in the children of adolescents. MCH staff received a grant from the FASD Foundation for MRFASTC Midwest Regional Fetal Alcohol Syndrome Training.

Through a grant from the National 4-H Council, a team (MCH adolescent consultant, KS Mentor Director, K-State Professor, 4-H Extension Agent, 2 college students and President of Communities in Schools of KS) received Positive Youth Development Training. The team will provide Youth Development trainings at locations with high-concentrations of youth in (e.g, community colleges, youth camps, youth sport events, universities).
Infrastructure Building:

The participants in the National Stakeholders Meeting Reconvene will continue work to develop a youth advisory council and support the pilot program in KC.

Infrastructure Building Services:

KDHE will continue to collaborate with all State agencies to maximize funds. KDHE will continue to look for and apply to new funding sources for teen pregnancy prevention programs.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	36	36	37	40	40
Annual Indicator	34.2	34.2	38.2	38.2	38.2
Numerator	11485	11485	13176	13176	13176
Denominator	33558	33558	34506	34506	34506
Data Source				KDHE. Smiles Across Kansas: 2007	KDHE. Smiles Across Kansas: 2007
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	40	41	41	42

Notes - 2008
Data Source: KDHE. Office of Oral Health. Smiles Across Kansas: 2007 Update - unpublished weighted data.

Data for 2008 is not available. 2007 data was used to pre-populate this performance measure.

Notes - 2007
Data Source: Smiles Across Kansas: 2007 Update - unpublished weighted data.

a. Last Year's Accomplishments
Direct Health Care Services:

The Kansas Bureau of Oral Health (BOH) did not provide direct dental health care services, but did assist partners in accessing resources to facilitate screening services in community settings, providing primary care clinic dental services, and charity dental services.

Enabling Services:

Regional Dental Hygienists provided oral health information and individual dental hygiene instruction to parents and caregivers of Children and Youth with Special Health Care Needs (CYSHCN). Working through contractor Oral Health Kansas, these parent educators meet with children and parents as well as the support service providers to raise awareness about the importance of oral health in overal health improvement.

BOH staff provided education to primary care pediatric providers on oral health topics including caries risk assessment and fluoride varnish education. Staff visited medical providers in their offices to encourage the use of fluoride varnish in EPSDT (Kan Be Healthy) exams.

BOH identified a national level speaker on the treatment and care of CYSHCN and held a free continuing education seminar for dental personnel. This was intended to encourage dentists and dental hygienists to treat special needs populations in their practices.

BOH provided the Primary Care Association with assistance on educating their dental providers about pediatric and special needs patients and collaborated on dental recruitment and workforce issues.

BOH partnered with a safety net clinic to provide an access point for dental care for patients with special needs who require sedation services. Funding provided by the Bureau's MCH Targeted Oral Health Service Systems grant funded a special needs day at the clinic.

BOH partnered with two safety net clinics to create and maintain school sealant programs providing funding and technical assistance.

Population Based Services:

Kansas law requires each child to have a yearly oral health screening. The BOH assisted schools in complying with this statute training screeners and helping schools organize screening dates. In the 2008-9 school year, over 56,000 children were screened. Screening data was collected and maintained in the BOH.

Infrastructure Building Services:

A comprehensive research study on dental workforce demographics, 2009 Kansas Oral Health Workforce Assessment, was completed.

A searchable web-based database of school screening data housed on the Bureau of Oral Health's website.

The Bureau has convened a group of policy makers who meet biannual to discuss workforce policy issues. In 2009 the Dental Workforce Cabinet created a new student loan re-payment program.

BOH staff are members of the Medicaid Advisory Group that works with the Medicaid agency to improve access to dental services for Medicaid recipients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide fluoride varnish training and oral health education to non-dental professionals.		X		X
2. Establish school oral health screenings and referrals.		X	X	X
3. Provide consultation and technical assistance to school based dental sealant projects.		X		X
4. Provide support and technical assistance to the Medicaid Agency on dental matters.				X
5. Provide leadership to the Oral Health Kansas Coalition.				X
6. Provide leadership to the Kansas Public Health Association Board Oral Health Section.				X
7. Provide education and dental access to Children and Youth with Special Health Care Needs.		X		X
8. Provide a forum for discussion of Dental Workforce policy, the Dental Workforce Cabinet.				X
9. Collaborate with private dentists and safety net clinics to provide technical assistance and education about underserved populations.				X
10. Targeted education and outreach to families to improve the oral health of children across Kansas.		X	X	X

b. Current Activities
Direct Services:

No direct services are planned.

Enabling Activities:

In June, a free continuing education seminar will be offered called "Caring for Patients with Special Health Care Needs". This is the third year in a row that the BOH will be sponsoring such a seminar. In September the safety net clinic providers will receive a free pediatric seminar at the annual Primary Care Conference. In addition, two dentists will be sent to the National Primary Oral Health Conference.

In 2010 new online modules on healthy eating and the effect of medications on oral health will be posted on KS-TRAIN.

Population Based Services:

The school based screening initiative will screen over 70,000 children in the 2009-2010 school year. The data will be posted in the fall of 2010.

Infrastructure Building Services:

A state oral health planning summit will be held in June to prepare for the drafting of a new 2011-2014 Kansas Oral Health Plan.

A Dental Workforce Cabinet Meeting in June will focus on the use of Extended Care Permit Dental Hygienists -- hygienists that work in public health areas.

Dental Recruitment Program at the BOH will work to recruit more dentists into underserved areas.

c. Plan for the Coming Year
Direct Services:

Enabling Services:

It is the final year of the Children with Special Health Care Needs project. This year will focus on sustainability of the parent education and clinical access programs created by this project.

A project intended to raise student's interest in dental careers among rural and minority students will start in Kansas Schools. Planning is underway for a summer program "Dental Camp" which will provide high school students with hands on dental career activities.

Population Based Services:

A rural access research project is currently underway and will be released in 2011. The data from the school screening initiative will be used to identify parts of the state of high need that could benefit from school based dental programs. Funding is being sought to increase the number of school sealant programs in rural and underserved school districts.

Infrastructure Building Services:

The Dental Recruitment Program will focus on recruiting dentists to underserved parts of Kansas.

A new state oral health plan will be released in early 2011.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	4	5.5	3.8	3.6
Annual Indicator	5.9	4.0	3.7	3.6	3.6
Numerator	33	23	21	21	21
Denominator	555339	574097	575333	582572	582572
Data Source				Kansas Vital Statistics,	Kansas Vital Statistics,

				2008	2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.6	3.6	3.6	3.6	3.6

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source:
Numerator = Death certificate (resident) data, 2008, Bureau of Public Health Informatics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2008

Notes - 2007
Data Source:
Numerator = Death certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE
Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2007

a. Last Year's Accomplishments
In 2008, the mortality rate for children ages <= 14 as a result of unintentional injury--motor vehicle crash (MVC) was 3.6/100,000 children, a 2.7% decrease from 2007 (3.7). Over the ten year period (1999-2008), there is a significant decreasing trend ($p<0.05$) detected in the rate of deaths to children aged 14 years and younger caused by MVCs in Kansas.

According to the 2009 Annual Report (2007 Data) of the Kansas State Child Death Review Board (SCDRB), death trends in 2007 were consistent with the previous year data. The Unintentional Injury-Motor Vehicle Crash (MVC) category showed an increase of 9% from 2006. The majority of the decedents in the MVC's were rear-seat passengers, many of whom were not using safety restraints. In 2008, 75% of children <= 14 were in child restraints, a 23% increase from 2007 (61%). This was attributable to the passage of a booster seat law in 2006. (Kansas Department of Transportation 2009 Annual Report).

The 2008 Kansas Traffic Accident Facts Book reported 99 child pedestrians with two deaths, and 102 pedal cyclists accidents resulting in two deaths for children age 1-14.

SAFE KIDS Kansas, Inc., a nonprofit coalition consisting of statewide local MCH programs/partners, is dedicated to preventing accidental injuries to Kansas children ages 0-14 and was affiliated with the SAFE KIDS Worldwide. The coalitions annually adopt a policy platform/priorities to influence the laws, regulations and institutional policies that affect childhood safety and increase funding support for programs and research. SAFE KIDS consisted of over sixty coalitions providing information/resources to prevent accidental injuries to Kansas children ages 0-14.

Kansas Traffic Safety Resource Office (KSTRO)/local communities continued CPS training/inspection/ provision of car seats providing education/resources for families with 31 of the 108 CPS sites being LHDs.

Enabling Services:

SAFE KIDS developed a policy platform for child safety restraints with an emphasis on a primary seat belt law and graduated drivers licensing. The Kansas House failed to pass a primary seat belt law, but did approved a plan to update Kansas's drivers licensing system with the passage of HB 2143 Graduated Drivers Licensing (GDL). Four key changes were made to the 12-month learner's permit period, limitation of non-sibling passengers the first six months of full licensing, limiting late-night driving for six months, and prohibiting use of cell phones while driving until restriction period is passed.

Population Based Services:

Of the 108 CPS stations in Kansas, 31 were in local health departments (LHD). Some sites had multi-lingual/Spanish-speaking technicians, services for the hearing impaired, and safety technicians trained on transporting children with special health needs (CSHCN). In 2009, SAFE KIDS reported 3,650 car seats were checked in at 281 local checkup events and 1,907 car seats were distributed to low income families, including 15 special needs child safety seats distributed through grants from the Kansas Emergency Medical Services for Children (EMSC) (http://www.safekidskansas.org/downloads/2009_Annual_Report.pdf)

The national initiative, Spot the Tot, provided education/demonstrations to parents and children regarding safety in/around cars including the dangers of back-over injuries and children left alone in vehicles.

SAFE KIDS facilitated local bike safety programs in 94 communities where 5,034 low-cost or free bicycle helmets were distributed to children ages 1-14. State Farm Companies and the KDOT gave monetary support for the program allowing local coalitions to distribute an additional 2,062 helmets through local initiatives.

MCH staff in LHD and school nurses continued to provide injury prevention information/education, including current laws, correct use/installation of car seats, booster seats and seat belts at clinics, in the community, including child care and schools, and at home visits.

Infrastructure Building Services:

Mini-grant funding from KDHE was awarded to 17 local communities for injury prevention programming. The Kansas Department of Transportation's (KDOT) Safe Routes to School and "Spot the Tot" program continues for for schools that wish to participate.

The 2009 MCH Orientation session for new MCH staff provided education, resources, and information related to child safety birth through age 18. The monthly ZIPS newsletter continues providing prevention/promotion information/resources.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Title V staff collaborates with partners on SAFE KIDS Advisory Council, and the Emergency Medical Services for Children Coalition to coordinate delivery of motor vehicle injury / death prevention information and resources to state and regional pa		X	X	X
2. State Child Death Review Board analyzes of deaths of children ages 0-18 that are involved in motor vehicle crashes.			X	
3. Provide information to local health departments and other public health practitioners on training and educational resources	X	X	X	X

to promote activities to reduce unintentional motor vehicle injuries and deaths, such as car seat installation / inspection.				
4. Link local health departments' to data resources that provide information of motor vehicle unintentional injury to facilitate development of regional / community strategies targeting specific populations / injuries / deaths.			X	X
5. Local MCH staff provides education and instruction to families with infants and young children on importance of proper Child Passenger Safety, graduated driver's licensing, and new laws for primary seat belt use and banning of texting.		X	X	X
6. Encourage community collaboration to seek out resources to assist in injury prevention programs such as Cycle Smart, Walk This Way, Spot the Tot and Safe Routes to School.			X	X
7. MCH provides education / resources for developing / delivering targeted MCH services for specific populations though annual orientation session for new MCH staff, the monthly ZIPS newsletter, and participation on statewide coalitions/committees.			X	X
8.				
9.				
10.				

b. Current Activities
Direct Services:

Child safety seats installation/inspection continues with additional training offered by KSTRO.

Enabling Services:

SAFE KIDS has 28 local coalitions covering 74% of Kansas children age 0-14. State MCH staff serves on the SAFE KIDS Advisory Committee, KDHE's Emergency Medical Services for Children Coalition, and the State Child Death Review Board identifying trends in child death.

Population Based Services:

KDOT reports on two new laws: HB 2130, a primary seat belt law, took effect May 27 allowing law enforcement officers to stop/ticket drivers/front seat passengers not wearing safety belts, without any other observed traffic/vehicle equipment violation. SB 300 prohibits a person who is operating a motor vehicle from using a wireless communications device to write, send or read a written communication. Law enforcement officers will issue a warning citation for violation until January 1, 2011 at which time the fine will be $60.
(http://www.ksdot.org/bureaus/offTransInfo/TRANSLIN/June/June-July10.pdf)

SAFE KIDS is promoting the 2010 International Walk to School Day for October 6. The Safe Routes to School program continues, as well as the Spot the Tot initiative, providing education/demonstrations to parents/children regarding safety in/around cars.

Infrastructure Building Services:

KDOT and SAFE KIDS continues to provide mini grants to communities with Safe Routes to School and other pedestrian/ bicycle / motorized vehicle safety programs.

c. Plan for the Coming Year
This National Performance Measure has been discontinued for SFY 2011.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	23	24	45
Annual Indicator	37.8	42.3	42.1	43.8	43.8
Numerator					
Denominator					
Data Source				National Immunization Survey, 2006 birth cohort	National Immunization Survey, 2006 birth cohort
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45	45	45	45	45

Notes - 2009
The 2009 column is populated with 2008 data (provisional, 2006 birth cohort). Data will be available in 2011.

Notes - 2008
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Provisional geographic-specific breastfeeding rates among children born in 2006, CDC's Breastfeeding National Immunization Data: Any by States: 2006.

http://www.cdc.gov/breastfeeding/data/NIS_data/2006/state_any.htm

Notes - 2007
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Final geographic-specific breastfeeding rates among children born in 2005, CDC's Breastfeeding National Immunization Data: Any by States: 2005.

http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm

a. Last Year's Accomplishments
In National Immunization Survey, 43.8% of Kansas children born in 2006 (provisional) were breastfed at least 6 months, 2.5% higher than children born in 2005 (42.1%). This compared to 43.4% for U.S children born in 2006. This estimate was getting closer to, but remained below the national Health People 2010 (HP2010) objective (50%). Over the 7-year period (2000-2006),

there was a significantly increasing trend ($p<0.05$) in the percents of Kansas infants breastfed at 6 months of age. The survey showd that low income mothers are less likely to breastfeed than their higher income counterparts.

According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families (below 185% of poverty level) participating in WIC, 20.6% of Kansas WIC infants were breastfed at least 6 months, 4.6 % lower than in 2007 (21.6%). This was 23.4% lower than the percent for U.S. WIC infants (25.4%) and was well below the HP 2010 objective. Over the 5-year period (2004-2008), there is statistically significant decreasing trend in the percents of Kansas WIC infants breastfed at 6 months of age.

Enabling Services:

Kansas Breastfeeding Coalition in partnership with KDHE implemented the Business Case for Breastfeeding grant through workshops and assistance offered to businesses throughout Kansas and billboards in three prominent locations along the Kansas Turnpike and other busy Kansas highways.

Designed and disseminated the "Mother's and Baby's First Weeks Log" and staff "Breastfeeding Evaluation Tool" to all local health departments and school nurses.

Population Based Services:

Supported Breastfeeding Peer Counselor Programs in 19 Kansas counties. Peer counseling was a significant factor in improving breastfeeding initiation and duration rates among women in a variety of settings, including economically disadvantaged and WIC populations.

Coordinate a public awareness campaign for World Breastfeeding Week in August 2009. Provide all clinics who submit a summary of their activity with up to $75 worth of breastfeeding education and/or resource materials.

Infrastructure Building Services:

Facilitated discussion of LHD staff in two counties to evaluate and develop breastfeeding strategies. Staff from a variety of programs within the LHD attended.

Presented information on the benefits of breastfeeding to the Perinatal Council of Kansas.

Supported Certified Breastfeeding Educator Training in October 2008.

Provided financial support to the Kansas LaLeche League 2009 spring continuing education conference for all health professionals.

Quarterly breastfeeding packets including a newsletter to share with other health professionals and new breastfeeding resources were distributed to 104 locations throughout the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support community breastfeeding coalitions by encouraging LHDs to play an active role.		X		
2. Communicate breastfeeding information to a variety of state				X

and community agencies.				
3. Disseminate breastfeeding newsletter for LHDs to send to community contacts.			X	
4. Support LHDs through WIC and MCH to continue and implement breastfeeding friendly policies.				X
5. Increase breastfeeding knowledge of LHD staff for both MCH and WIC programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Enabling Services:

Support evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets will include a newsletter and breastfeeding resources which can be shared with other health professionals in their communities.

Support growth of Breastfeeding Peer Counselor programs in 16 additional counties.

Population Based Services:

Ongoing training and partnerships including the Business Case for Breastfeeding to support working breastfeeding mothers.

Coordinate a public awareness campaign for World Breastfeeding Week in August 2010. Provide $200.00 worth of breastfeeding education and/or resource materials to 2 clinics with the most innovative implementation of the World Breastfeeding Week theme.

Infrastructure Building Services:

The Kansas WIC Program plans to hire a public health nurse to coordinate the Breastfeeding Peer Counselor Program.

Breastfeeding data from the Kansas Live Birth Certificate are not yet available. Information on the importance of collecting breastfeeding information and the benefits of breastfeeding will be sent to hospitals identified as submitting incomplete certificates.

Providing the "Using Loving Support to Grow and Glow in WIC Breastfeeding" training to all Kansas WIC staff. Trainings are open to all other LHD staff who work with breastfeeding women.

Support Certified Breastfeeding Educator Training in October 2009 and June 2010.

c. Plan for the Coming Year
Enabling Services:

Support evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets will include a newsletter and breastfeeding resources which can be shared with other health professionals in their communities.

Support growth of Breastfeeding Peer Counselor programs in additional counties.

Population Based Services:

Work with local Breastfeeding Coalitions, the LaLeche and other interested parties to promote breastfeeding friendly employee policies.

Support World Breastfeeding Week activities.

Infrastructure Building Services:

Work with LHD to improve the clinic atmosphere to support breastfeeding dyads through local needs assessment and policy development.

Work with LHD to improve staff competencies related to breastfeeding, including helping to sponsor Certified Breastfeeding Educator Training in at least one location.

Provided financial support to the Kansas LaLeche League continuing education conference for all health professionals.

Support at least one Certified Breastfeeding Educator Training.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98
Annual Indicator	87.9	95.3	96.4	97.4	98.0
Numerator	35825	39951	41388	41485	40744
Denominator	40734	41910	42947	42584	41564
Data Source				KDHE. Kansas Newborn Screening program, 2008	KDHE. Kansas Newborn Screening program, 2009
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98.2	98.2	98.6	98.6	98.8

Notes - 2009
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2009 .
Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

Notes - 2008
DATA SOURCE:
Numerator= KDHE. Bureau of Family Health. Kansas Newborn Screening program for Calendar Year 2008 .
Denominator= KDHE. Office of Health Assessment. Kansas Live Birth by Occurrences.

Notes - 2007
Data Sources: Newborn Hearing Screening program 2007 (numerator); Vital Statistics occurrent births for 2007 (denominator).

a. Last Year's Accomplishments
Kansas continued to screen at 95% or better since 2003. The percent of newborns screened before hospital discharge was 98% in 2009, an increase of 1.2% since 2007. Percentages for 2005 were reduced due to the implementation of a new web-based birth certificate system through the Office of Vital Statistics that did not allow for records from birth to be extracted for 15 months significantly impacting the program's ability to track infants needing additional testing in that first month of life.

Enabling Services:

Collaboration and funding was provided for assistance with parent-to-parent support, and continual work to develop the parent-driven Kansas Hands & Voices Chapter family support organization.

The Audiology/EHDI Coordinator, Advisory member, and parent representatives attended an EHDI Family Support National Meeting to assist with development of family support infrastructure and services for children and their families. Information and resources for outpatient and diagnostic audiology providers were provided.

Population Based Services:

The newborn hearing screening was implemented at the local level by hospitals, birthing centers or other obstetrical/newborn services licensed facilities. SoundBeginnings (SB) administered the statewide system for newborn Early Hearing Detection and Intervention (EHDI) including data management tracking and surveillance.

Infrastructure Building Services:

The SB Advisory Committee continued to meet quarterly and establish goals for each year to support the program and stakeholders.

Lindy Russell, Data Coordinator was hired as a temporary employee through the HRSA grant to help improve and reduce the Loss to Follow-up and Loss of Documentation rate.

SB visited 28 birthing hospital and 8 Part C Infant Toddler networks to retrain and re-educate the coordinators and hearing screeners.

Funding was provided for five birthing hospitals/clinics and five selected Part C networks to receive Otoacoustic Emission screening equipment. An Auditory Brainstem Response machine was also purchased for the state's largest birthing facility to help reduce their Loss to Follow-up rate which will provide diagnostic testing without sedation on the birth to three years of age population.

SB was able to help provide the attendance of 13 state team members to attend the Early Hearing Detection and Intervention Annual conference in Chicago. This included the SB staff, 2

parents, an audiologist, 2 Infant Toddler representatives, a representative from the Kansas School of the Deaf, and a KDHE Epidemiologist. SB was able to provide funding to three local audiologist to attend the EHDI conference on Pediatric Audiology.

Presentations were provided by Liz Abbey, SB Coordinator/Audiologist at the Kansas Academy of Family Physicians, Kansas Chapter AAP, Sound START Train the Trainer Conference, and Little Ears and Hands, a Wichita Parents of Deaf and Hard of Hearing group.

A presentation were provided by Garry Kelly, KDHE epidemiologist, at the annual EHDI Conference with a focus on infant and parental characteristics at birth associated with Lost to Follow-up and Lost to Document in Kansas newborn hearing screening.

Funding in the amount of $50,000 was approved from State general funds to implement a hearing aid loan bank. 27 hearing aids were loaned out to 16 children.

Participated in State meetings working with stakeholders, Early Childhood Hearing Outreach State Team meeting, Kansas Commission for the Deaf and Hard of Hearing Board Meetings and activities, Sound START Committee meetings, and Deaf Blind Consortium meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue data submission through the web-based birth certificate (VRV) reporting system.			X	
2. Continue quarterly meetings of the Sound Beginnings Advisory Committee.				X
3. Continue the education training to professionals on early intervention.				X
4. Collaborate to assist Kansas Hands and Voices Chapter enabling parental input and parent to parent support.		X		
5. Continue dissemination of Newborn Hearing Screening brochures for families to hospitals, etc.				X
6. Support to hospitals to enhance screening equipment.				X
7. Family and audiologist consultants to assist reduce loss to follow-up.				X
8. Formalization of a regional program to assist newly identified families at first contact.				X
9. Continued attendance at EHDI, parent support and deaf education focused meetings.				X
10.				

b. Current Activities
Enabling Services:

Continued collaboration and funding for Kansas Hands & Voices parent-driven family support organization.

Population Based Services:

The screening is implemented at the local level by birthing facilities. SB administers the statewide system for EHDI including a data management tracking and surveillance system.

Infrastructure Building Services:

SB will continue with advisory committee meetings and dissemination of brochures.

Continued submission of screening and diagnostic evaluation results through fax, mail and email. Follow-up is completed on missed, NICU, and failed screens by staff and by EHDI Coordinator for confirmed hearing loss to medical home providers, Part C local networks and families.

Site visits are made to hospitals and audiologists. Information and technical assistance is provided to all stakeholders on program via phone and email.

Support through grants to assist with reducing refer rate to include Automated Auditory Brainstem Response equipment has been provided to Level III NICU Hospitals.

Work related to reducing loss to follow-up and loss to documentation and tracking, surveillance and integration continues with support from grants.

c. Plan for the Coming Year
Enabling Services:

Continue to provide assistance with the Kansas Hands and Voices Chapter family support organization group specifically for families of children who are deaf or hard of hearing to promote Parent-to-Parent program services to families, assisting with a family support activities and parent consultants.

Population Based Services:

The screening will be implemented at the local level by birthing facilities including hospitals, birthing centers or other obstetrical/newborn services licensed facilities. SB will administer the statewide system for Early Hearing Detection and Intervention including a data management tracking and surveillance system.

Infrastructure Building Services:

Continue submission of hearing screening results through the web-based birth certificate system and the Sound SB database to accept the required Healthy People 2010 data fields including race, ethnicity, language spoken in the home, birth defects, and transferring hospital.

Support through CDC grant working towards enhancements to the SB web-based data system, Auris, will allow birthing facilities and audiologists to directly access their patient's record and input hearing screen reports. It is anticipated this will help reduce the Loss to Follow-up and Loss to Documentation cases.

Collaborate with the Kansas School for the Deaf, Infant Toddler Services, University of Kansas Deaf Education program, tiny-k networks, Hartley Family Center and the St. Joseph Institute for the Deaf to provide assistance and training for personnel at tiny-k networks working with families of children identified with hearing loss and develop a regional program to assist in first contacts with families.

Continue providing technical assistance to hospital personnel, audiologists, early interventionists, medical homes and other stakeholders of newborn hearing screening and intervention services. Audiologist Consultants and Family Consultants will be contracted to assist local communities in reducing loss to follow-up and/or documentation.

SB Newborn Hearing Screening Program Advisory Committee will continue to meet quarterly. The committee has established goals for the advisory year which begins in January including parent communication and family concerns; focus on education to all members involved in early

intervention and including the focus of the family perspective; and information sharing of legislative issues or advocacy from the Kansas Commission of the Deaf and Hard of Hearing or other organizations that are related to early hearing detection and intervention.

Support through mini grants will be provided to two hospitals that have a Level II or III NICU to purchase Automated Auditory Brainstem Response (AABR) equipment.

Staff, parents, and the Part C Coordinator will continue to attend conferences focusing on Early Hearing Detection and Intervention (EHDI) issues, family support and Deaf Education including the National EHDI conference.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	6	6.5	7	7
Annual Indicator	6.2	7.3	7.7	11	11
Numerator					
Denominator					
Data Source				US Census. ASEC supplement. Table HI05	US Census. ASEC supplement. Table HI05
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10.5	10	10	9.5	9.5

Notes - 2009
DATA SOURCE: U.S. Census Bureau and Burau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2008. Addition information can be found at http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm

Data for 2009 is not available. 2008 data was used to pre-populate this performance measure.

Notes - 2008
DATA SOURCE: U.S. Census Bureau and Burau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2008. Addition information can be found at http://www.census.gov/hhes/www/cpstables/032009/health/h05_000.htm

Notes - 2007

DATA SOURCE: U.S. Census Bureau and Burau of Labor Statistics. Current Population Survey. Annual Social and Economic (ASEC) supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2007. Addition information can be found at http://www.census.gov/hhes/www/macro/032008/health/h05_000.htm

a. Last Year's Accomplishments

According to the Kansas Action Children (KAC) report, "Children's Health Insurance Coverage in Kansas", "roughly 338,000 - or 12 percent of the state's population - were uninsured (U.S. Census Bureau, 2009) . . . [With] approximately 72,000 Kansas children. . . uninsured, making children account for 21 percent of the state's uninsured population.

Medicaid and HealthWave, the State CHIP) was directed by the Kansas Health Policy Authority (KHPA) through two managed care groups: Children's Mercy Family Partners and UniCare. State agencies reduced budgets in response to ongoing quarterly budget deficits, including KHPA that reduced staffing in critical areas of Medicaid operations. In May 2009, the State Medicaid director reported a backlog of 40,000 unprocessed applications.

The KHPA reports in SFY 2009, "children and families in Medicaid accounted for half (51.9%) of the total population in Kansas medical assistance programs, but they accounted for only 20.9% of total expenditures"
http://khpa.ks.gov/legislative/download/2010Testimony/Medicaid%20Savings%20Options%20-%20April%2026%20-%204-26-2010%20pqh.pdf with over 69% of total expenditures accounted for by the elderly and adult disabled.

As of April 2010, Medicaid enrollment had grown in FY 2010 approximately 15,000-18,000 persons with most of the recent growth concentrated among families and low-income children (KHPA, 2010). Overall costs among the Children's Health Insurance Program (CHIP) population (HealthWave-21) grew 16.2%, and a little over half this growth was explained by the 8.8% rise in the number of children covered (KHPA, 2010).

Governor Mark Parkinson issued a series of fiscal year 2010 budget allotments that included a 10% reduction in payments to Medicaid service providers.

Direct Services:

The Kansas Association for the Medically Underserved (KAMU) reported 36 primary care safety net clinics provided a medical home for patients with over 90% of patients having incomes less than 200% of poverty. Eighteen clinics received dental hub funding from the State and/or private foundations. SFY2010 Primary Care Clinic (PCC) grant awards totaled $5,515,840 million with $750,000 prescription assistance funding.

Enabling Services:

The KHPA was to extend HealthWave eligibility limits from 200 to 250% of poverty beginning July 1, 2009 through the Health Care Package approved by the 2008 legislature. No funding was allocated for the expansion, thus the expansion did not occur until Kansas accepted ARRA funding. According to www.recovery.gov of the $993 million dollars received, $71,575,227 was designated to the Medical Assistance Program.

Population Based Services:

The Kansas Health Institute (KHI) analyzed information provided by 100 underinsured Kansans in phone interviews conducted by the University of Kansas Survey Research Center during the first five months of 2009 to determine if either they or a family member experienced some difficulty or limitation related to the insurance.

MCH educated partners and families of children about the availability or/eligibility for Medicaid/HealthWave through community outreach with other social service/health providers, schools, child care settings, and home visiting programs.

Infrastructure Building Services:

On June 4, 2009, KAC convened a statewide Children's Health Coverage Summit of advocates, service providers, state agency personnel and philanthropic leaders to discuss implications of "the Children's Health Insurance Program Reauthorization Action (CHIPRA), state-level advocacy and effective strategies for enrolling / retaining children in Medicaid and the Children's Health Insurance Program (CHIP)" (KAC, 2009). Recommendations from the 23 member working group's four meetings identified significant barriers to reducing the number of uninsured children and recommendations: targeted marketing in communities with high rates of uninsured children, data collection/analysis of uninsured children, as well as those whose parents did not renew enrollment, use of outreach workers, consumer feedback, simplification of the enrollment process, and use of promising practices identified in other states.

KHI reported the U.S. Department of Health and Human Services awarded more than $9 million to the Kansas Health Information Exchange (KanHIT) Project to underwrite the effort to build a statewide system for transferring digital patient records among medical providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide information to MCH programs related to the State Health Access Program (SHAP) located in safety net clinics.		X	X	X
2. Provide Medicaid/HealthWave Program information and applications through outreach activities in communities.		X		X
3. Assist families with Medicaid/HealthWave application and the establishment of a medical home.		X	X	X
4. Promote local education agency outreach activities by school nurses, school social workers, and school psychologists to enroll Medicaid/HealthWave eligible children.		X	X	X
5. Utilize home visiting services to assist families with Medicaid/HealthWave enrollment.		X	X	
6. Link students with Medicaid/HealthWave coverage through school health services.		X	X	
7. Promote local coordination and collaboration between agencies to link hard-to-reach and disparate populations to Medicaid/HealthWave Programs.			X	X
8. Assist local health agencies to create a community plan for linking families to safety net clinics/dental hubs and in providing care for those uninsured children who remain ineligible for Medicaid/HealthWave Programs.	X	X	X	X
9. Develop strategies to inform public of implications of health reform and Patient Protection and Affordable Care Act (PPACA).		X	X	X
10.				

b. Current Activities

State officials requested permission to increase HealthWave-21 premiums by $40/family/month to reduce SGF expenditures impacting almost 14,000 children/7,700 families if approved. KHPA is studying implications.

CMS contacted KHPA regarding the backlog of 13,400 Medicaid determination/redetermination applications. KHPA renegotiated a contractor contract to reduce cost of processing applications.

KHI convened general public, media, Legislative, state, legal, insurance industry, hospital, health policy research, health foundation, health care industry and advocacy representatives to discuss implications of the Patient Protection and Affordable Care Act (PPACA).

Direct Services:

KAMU reports in 2008, 189,422 patients made 566,689 visits to the 40 main safety net clinics/28 satellite sites with 6 clinics limiting caseloads to uninsured patients.
Enabling Services:

HealthWave-21 is now available to uninsured children up to age 18 whose families earn < 241% Federal Poverty Level (FPL) with premiums dependent on income.

Population Based Services:

Medicaid/HealthWave enrollment activities are conducted in community settings.

Infrastructure Building Services:

Kansas received $1,930,490 million in competitive federal funding from Health Resources Services Administration (HRSA) to develop an electronic online HealthWave/Medicaid application. KHPA will coordinate the State Health Access Program (SHAP) staffed by 12 community outreach workers located in safety net clinics.

c. Plan for the Coming Year
Direct Services:

MCH will promote PCC/private provider medical home access. The Kansas Statewide Farmworker Health Program will coordinate a state-wide case management system for migratory/seasonal farmworkers. Covered health service vouchers from state-funded access point agencies made up PCC/local health departments will be used by regional case managers/health promoters assisting clients in obtaining Medicaid/HealthWave, M&I, nutrition/WIC, well-child exams, and family planning services.

Enabling Services:

MCH will continue to work with state/local partner to assist MCH staff in locating insurance coverage and access to care for children.

Population Based Services:

MCH will support/promote outreach/enrollment activities in local agencies for Medicaid-eligible women/children encouraging health services in a medical home referring ineligible families to safety net clinics.

Infrastructure Building Services:

The Health Resources and Services Administration (HRSA) reports KHPA will expand/coordinate health insurance coverage to children between 200-250% of Federal Poverty Level (FPL) and Presumptive Eligibility (PE) for pregnant women through the State Health Access Program (SHAP). This technological initiative will assist in implementing the Legislature's mandate to expand coverage to children between 200% - 250% of FPL and PE for pregnant women and reduce the number of applications not processed within the 45 day standard.

"KHPA will hire technical and program staff (including 12 out-stationed Eligibility Workers);

deploy. . .300 computers/laptops and scanners to community-based agencies, train agency staff in use of the eligibility/enrollment tools. . . develop linguistically/culturally appropriate outreach, marketing and educational materials to assist in increasing insurance penetration rates in targeted populations and communities"(Retrieved June 2, 2010, from http://www.hrsa.gov/statehealthaccess/kansas.htm). MCH will educate providers about SHAP program to enroll eligible children in health insurance programs and assist in identifying/implementing strategies increasing enrollment and linking to medical homes.

KDHE will be the designee for a statewide infrastructure for health information exchange (HIE) facilitating strategic/operational plans with the primary goal to enable data sharing among healthcare stakeholders to coordinate patient care and support public entities to achieve population health goals and assist to develop medical homes.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		30	30	29	29
Annual Indicator	30.3	30.8	30.1	30.0	30.0
Numerator	10114	6900	9474	10306	10306
Denominator	33378	22404	31476	34352	34352
Data Source				Pediatric Nutriton Surveillance System, 2008	Pediatric Nutriton Surveillance System, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	28	28	28	28

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2008 (Kansas WIC database).

Notes - 2007
Data Source: Pediatric Nutriton Surveillance System (PedNSS), 2007 (Kansas WIC database).

a. Last Year's Accomplishments
According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assessed weight status of children from low-income families (below 185% of poverty level) participating in WIC, 30.0% of low-income children ages 24-59 months in Kansas were overweight (at or above 85%) or obese (above 95%). This percent was not significantly different from the percent nationally

(31.3%). The percentage of WIC participants overweight or obese remained about the same as 2007 (30.1%). There was an increasing trend during 2000-2004 followed by a slight decreasing trend or remained stable since 2004. The annual percent changes were significant only for the segment corresponding to 2000-2004 (6.04, -0.47, respectively).

Enabling Services:

Worked with the Office of Health Promotion to promote a statewide event on May 1, 2009. The event focused on increasing physical activity among 3rd grade students.

Training websites and resources that promote good nutrition and physical activity were published in the resources and events section of the Zero to age 21: Information for Promoting for Public Health Professionals working with Kansas Kids (ZIPS) newsletter throughout the year.

Infrastructure Building:

Approximately 85 physical education teachers, school nurses and local or state health department staff attended the 2010 Symposium on Adolescent Health Issues on February 5, 2010. Dr. Amy Cory presented a session titled "Adolescent Obesity: The Sequelae of Overnutrition and Its Relationship to Injury Prevention."

Four state staff attended CDC's Weight of the Nation Conference. An inservice reviewing this conference was provided to all MCH state staff in August 2009.

Three state staff attended the 2009 Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors.

LHDs were encouraged to attend the October 2009 Built Environment summit.

Population Based Service

School nurses were surveyed to assess if school aged children are being weighed, measured and referred, as appropriate. Base line data indicated that approximately 20% of nurses are assessing BMIs. The importance of assessing height, weight and BMI's of school aged children was covered in newsletters and trainings targeting school nurses.

The new WIC Food Packages which provide a cash value check for fresh, frozen or canned fruits and/or vegetables were implemented in Kansas on August 1, 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.		X		
7. Promote consistent messages with best evidence available.		X	X	
8.				

9.				
10.				

b. Current Activities
Enabling Services:

Continue working with the Office of Health Promotion to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. This event was May 7, 2010.

Participating in Children's Health in All Policies (Chap) Advisory Panel conversations about Policy Options for Addressing Obesity in Kansas Children sponsored by the Kansas Health Institute.

Infrastructure Building:

Assist LHDs in identifying and accessing funding streams that could potentially support nutrition and physical activity programs at the community level and publishing the resources in ZIPS.

Facilitate MCH staff in obtaining continuing education to promote, deliver and evaluate services to support healthy eating and physical activity by encouraging attendance at the 2011 Symposium on Adolescent Health Issues.

Work with the Coordinated School Health program, Blue Cross and Blue Shield Foundation of Kansas, Healthy Kids Kansas and Community Health Assessment to assist communities, child care facilities and schools in obtaining grants for communities to use to address healthy eating and physical activity.
Population Based Service

Survey school nurses to assess if school aged children are being weighed, measured and referred, as appropriate.

Promote increased intake of fruits and vegetables by increasing the amount of fruits and vegetables provided to WIC women.

c. Plan for the Coming Year
Enabling Services:

Model health education and physical activity for 3rd grade students in Kansas, by working with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. Nearly half of all third graders in the state of Kansas participate each year.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

Population Based Service

Survey school nurses to assess if school-aged children are being weighed, measured and referred, as appropriate. Importance of assessing these parameters will be covered in newsletters and trainings.

Work with the Office of Health Promotion and other stakeholders to design and promote a consistent and culturally appropriate nutrition and physical activity messages.

Infrastructure Building:

Assist LHDs in identifying and accessing funding streams that could potentially support nutrition and physical activity programs at the community level.

Strengthen processes and mechanisms to assist LHD in successful grant writing by identifying online training resources and workshops or through support of speakers at public health conferences.

Enhance the socioeconomic development, organization and project management, policy research, and meeting facilitation and data collection and evaluation in state and local programs.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12.3	13.5	13.5	13
Annual Indicator	14.0	14.2	13.7	13.8	13.8
Numerator	5577	5814	5729	5763	5763
Denominator	39701	40896	41951	41815	41815
Data Source				Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13	12.5	12.5	12.5	12.5

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Birth certificate (resident) data, 2008, Bureau of Public Health Informatics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

a. Last Year's Accomplishments

Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is a key predictor for infant mortality.

In 2008, 13.8% (5763) of Kansas women reported smoking during the last three months of pregnancy, a 0.7% increase from 2007 (13.7). Among women who reported smoking during the last three months of pregnancy, 53.1% reported Medicaid as principal source of payment for this delivery. This was a 4.7% increase from 2007 (50.7%). Over the four year period (2005-2008), there was no significantly increasing or decreasing trend detected.

Direct Services:

Tobacco cessation assistance was provided to pregnant women referred to the Kansas Tobacco Quitline (Quitline) and to local tobacco cessation clinical provider services.

Enabling Services:

MCH grantee prenatal care coordinators throughout the state provided screening, counseling and referral to tobacco cessation services available in their local communities.

Population Based Services:

MCH grantees and other prenatal providers were encouraged to use web resources provided by the National Partnership to Help Pregnant Smokers Quit.

Infrastructure Building Services:

In collaboration with the MCH Program at KDHE, the Kansas Tobacco Use Prevention Program (TUPP) encouraged local agencies to use the Quitline and other smoking cessation materials. These local agencies affect about 70% of Kansans. Also, local prenatal care providers were encouraged to use resources provided by the National Partnership to Help Pregnant Smokers Quit.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH encourages local health department (LHD) staff and local perinatal healthcare providers to attend tobacco cessation trainings when available to help decrease the number of pregnant women that smoke tobacco.			X	X
2. MCH encourages LHD staff and local perinatal healthcare providers to refer pregnant women to Quitline and local tobacco cessation services to help decrease the number of pregnant women that smoke tobacco.	X		X	X
3. MCH and the Kansas TUPP coordinate referrals with LHD programs and local perinatal healthcare providers to provide a linkage for pregnant women to tobacco cessation services.		X		X
4. LHD and local perinatal healthcare staff trained in the use of the 5 A's counseling approach to smoking cessation provide brief interventions to assist pregnant women to quit smoking tobacco.	X			
5. MCH staff link LHD and local perinatal healthcare staff to web resources provided by the National Partnership To Help Pregnant Smokers Quit.		X		X

6. MCH staff provides LHD and local perinatal healthcare staff with other relevant tobacco cessation resources via the Web, educational conferences, newsletter articles and through routine communications.		X		X
7. MCH staff educates LHD and local perinatal healthcare staff to assess pregnant women for smoking behaviors and tobacco use and provides information on the risks associated with continued smoking and to refer to local smoking/tobacco cessation servi		X		
8. MCH staff in collaboration with the Kansas TUPP and partnering tobacco-free coalitions will continue to monitor local and state-wide smoking/tobacco cessation ordinances/legislation.				X
9. Kansas smoke free legislation passed in 2010 session.				X
10. MCH staff will provide training on life course development and social determinants of health.		X		

b. Current Activities
Direct Services:

Pregnant women are provided tobacco cessation assistance by referrals to the Quitline, local healthcare provider tobacco cessation programs, and local activities through community coalitions and youth organizations.

Enabling Services:

Prenatal providers and MCH local agencies are given relevant tobacco cessation information/resources through newsletter articles, involvement with the Kansas TUPP and routine communications with MCH staff. Referrals to the Quitline and local cessation services are provided and local agency staff is encouraged to screen, educate and refer pregnant women to appropriate resources.

Population Based Services:

MCH grantees and other prenatal providers are encouraged to use web resources provided by the National Partnership to Help Pregnant Smokers Quit.

Infrastructure Building Services:

Continue evaluation of birth outcomes and smoking rates compared with local agency efforts in prenatal smoking prevention and cessation.

Kansas TUPP and MCH staff encourages local agencies to use the Quitline and other materials to aid people to quit smoking.

The Kansas TUPP provides updates to interested stakeholders evaluating the efforts of participating organizations implementing the 5 A's approach and on many other tobacco related issues.

Kansas legislature passed a law that makes almost all workplaces, restaurants and bars smoke free with an exception for casino floors in the 2010 legislative session that will go into effect July 1, 2010.

c. Plan for the Coming Year

Direct Services:

Tobacco cessation assistance will continue to be provided to pregnant women utilizing the 5A's tobacco use prevention method through local tobacco cessation clinical provider services with added support from the Kansas Tobacco Quitline.

Enabling Services:

In collaboration with the Kansas TUPP, MCH grantee agencies and local prenatal care providers will provide screening, counseling and referral services for pregnant women and women of reproductive age. The Quitline, local tobacco cessation services and activities of local community coalitions will assure education and support to help women quit using tobacco.

MCH staff will continue to provide relevant tobacco cessation information/resources through newsletter articles and in routine communications to local agencies and local healthcare providers.

Kansas home visitation staff will provide outreach services to pregnant women and their families offering smoking cessation resources and referrals.

Currently Medicaid does not pay for tobacco cessation counseling. Medicaid does pay for the Zyban and Chantix patch but does not pay for nicotine gum, spray, inhaler, or lozenge. MCH staff will encourage Medicaid reimbursement for tobacco cessation counseling.

MCH staff will further develop relationships with partnering organizations, stakeholders, programs and agencies to maintain and develop tobacco cessation resources for pregnant and preconceptional women.

MCH staff will provide information on life course development and social determinants of health to local health department staff.

Population Based Services:

MCH staff will encourage grantees and partners to pursue available tobacco cessation training and refer pregnant women to the Quitline and other local tobacco cessation resources for follow up support services.

Infrastructure Building Services:

Some capacity is in place to provide tobacco cessation counseling and referral by prenatal service providers in the state. MCH staff will provide technical assistance to local grantee agencies regarding billing for tobacco cessation counseling in an effort to support sustainability and encourage local programs to use web resources provided by the National Partnership to Help Pregnant Smokers Quit.

MCH staff will monitor data on tobacco cessation sent in by local MCH grantees serving pregnant women.

MCH staff in collaboration with the Kansas TUPP and partnering tobacco-free coalitions will continue to monitor local and state-wide smoking/tobacco cessation ordinances/legislation.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.3	8	7.5	9.4	9.3
Annual Indicator	7.9	9.5	10.1	11.1	11.1
Numerator	48	58	61	67	67
Denominator	610153	607746	606239	604131	604131
Data Source				Kansas Vital Statistics, 2006-2008	Kansas Vital Statistics, 2006-2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	10.8	10.6	10.4	10

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source:
Numerator = Death certificate (resident) data, 2006-2008, Bureau of Public Health Informatics, KDHE

Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: X60-X84,Y870.

Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2006-2008

Notes - 2007
Data Source:
Numerator = Death certificate (resident) data, 2005-2007, Center for Health & Environmental Statistics, KDHE

Reporting years were combined to calculate 3 year rolling averages due to small sample size.
ICD-10 coding: X60-X84,Y870.

Denominator = U.S. Census estimates (Bridged-Race Vintage data set), 2005-2007

a. Last Year's Accomplishments
In 2008, the suicide rate among Kansas youth ages 15-19 was 10.5 per 100,000. This was 3.7% lower than 2007 (10.9 per 100,000). For 2004-2006, the suicide rate for Kansas youth (9.5) was 23.5% higher than the U.S. rate (7.7). For the period 1997-2008, using rolling 3 year averages, there was a decreasing trend in completed suicides by Kansas youth (15-19) during 1997-1999 and 2003-2005 followed by a increasing trend from 2003-2005. The annual percent changes were significant for both segments (-6.6, 11.0, respectively).

In 2006, youth suicide was the second cause of death in Kansas 15-24 year olds. For the U.S.

(the most recent year national data for this age group is available) suicide was the third cause of death for this age group.

According to the 2005 Kansas Youth Risk Behavior Survey (YRBS), 13.0% of Kansas high school students had seriously considered attempting suicide during the past 12 months. This had risen to 13.9% in 2007, about 1 out of every 7 students. The percentage of students who made a plan about how they would attempt suicide during the past 12 months was 9.6% in 2005 and again in 2007 (1 of 10). Of students surveyed in 2005 and again in 2007, 6.5% and 6.7% respectively of the students who were surveyed actually attempted suicide one or more times during the past 12 months. The percent of students that attempted suicide and had to be treated by a doctor or nurse during the past 12 months was 1.6% in 2005 and 2.1% in 2007. Often the youth who attempted suicide had associated mental health or other behavioral concerns such as depression, substance abuse, and a sense of hopelessness, increased stress and a lack of family support.

Direct Services:

School nurses and school counselors continued to link families to family therapy counseling through the local mental health consortium and some used telemedicine technology that linked the school site to regional mental health centers and Kansas University (KU) providers of individual therapy and consultation services.

Enabling Services:

The mental health consortiums continued to provide education to school staff through presentations at conferences for training in best practice in screening and early detection of depression and suicidal ideation in the school aged population.

School nurses received Yellow Ribbon's Suicide Prevention Gatekeeper training and support via MCH school nurse consultants through conference presentations and newsletter articles.

Population Based Services:

According to the school nurse survey data, in 2007-2008 school year, 32% of the nurses reported a school suicide prevention program within their school. In 2008-2009 that number increased to 42%.

Infrastructure Building Services:

A task force, ABCD+ provided education and resources to assist primary providers in screening for development and mental health disorders in children, adolescents and new mothers.

The Suicide Prevention Subcommittee (SPS), an entity of the Governor's Mental Health Services Planning Council continued to promote the Kansas Suicide Prevention Plan and look for collaborative partners.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participate in the Governor’s Mental Health Services Planning Council and SPS to promote statewide suicide prevention strategic plan.		X	X	X
2. Work with the SPS to develop culturally appropriate, effective suicide prevention strategies for adolescent populations in				X

Kansas.				
3. Develop infrastructure and provide awareness of mental health/suicide specialist so referral sources will be available when needed.		X		X
4. Assist making linkages from Kansas schools to regional mental health centers for counseling and mental health services to decrease suicide ideation.		X		X
5. Ask school nurses for feedback if they are implementing a suicide prevention program in their schools through the School Nurse Survey to evaluate program implementation.				X
6. ABCD+ task force will develop KidLink Resource Directory.				X
7. ABCD+ will develop and deliver education to healthcare providers in the use of evidence-based screening tools and appropriate early intervention resources.		X	X	X
8.				
9.				
10.				

b. Current Activities
Direct Services:

A new psychiatric hospital, Wheatland Psychiatric Hospital, serving children living in western and central Kansas began taking patients May 3.

Kansas schools connect to the Telemedicine network.

In 2008-2009, School Nurse Survey data shows 42% of schools have suicide prevention programs.In 2009-2010 that number increased to 48.5%.

Enabling Services:

Juvenile Justice Authority centers received Bright Futures in Practice, Mental Health Tool Kit, Vol. II, to improve EPSDT suicide screening/interventions.

School nurses receive Yellow Ribbon Suicide Prevention information.

Population Based Services:

The Statewide School Nurse Conference will offer a session on mental health/self-mutilation detection education on body piercing, tattoos and mutilation.

Infrastructure Building Services:

MCH staff assures best practice information is available/distributed to those working with teens.

The Kansas Chapter of the American Academy of Pediatrics and KDHE MCH staff convened a multi-agency task force to increase the number of children ages 0-18 that receive mental health screening/appropriate mental health referral/treatment.

Survey data of healthcare providers on the issues of mental health diagnosis/treatment of children/adolescents reveal pediatric providers are uncomfortable diagnosing/managing mental health disorders, even common ones such depression and anxiety. The survey suggests an overwhelming majority of providers lack of resources to assist them.

c. Plan for the Coming Year
Direct Services:

Kansas schools will continue to connect to the Telemedicine network, their regional mental health centers, Kansas University (KU) and the Wheatland Psychiatric Hospital, to provide mental health services to rural areas of Kansas.

School nurses/counselors will continue to provide suicide prevention interventions in the school setting.

Enabling Services:

Suicide prevention will be addressed at the annual Statewide School Nurse Conference to promote the continued upward trend of suicide prevention programs in schools.

Suicide prevention articles will be published in MCH and school nurse newsletters. MCH staff will actively seek opportunities for Kansans' to improve suicide prevention skills and interventions.

Population Based Services:

School nurses will be encouraged to continue initiation of suicide prevention programs in schools.

KDHE will support efforts through consortiums to reduce access to lethal means and methods of self-harm. This will include working with Kansas Safe Kids to enact stricter gun laws in Kansas.

Infrastructure Building Services:

MCH staff will continue to promote the goals and strategies of the Kansas Suicide Prevention plan.

The SPS will continue to work to secure sustainable funding for the suicide prevention efforts in KS.

The SPS is proposing changes to the Kansas Board of Healing Arts asking that general practitioners have additional mental health training in order to treat suicidal patients more effectively in small communities. SPS is asking the Behavioral Sciences Regulatory Board to increase certification requirements for professionals specialized in suicide prevention.

The ABCD+ Task Force secured funding to develop an easily accessible web-based resource list titled KidLink Resource Directory with contact information including a stratified level of care of all mental health providers and therapists that serve the pediatric population, public and private, in Kansas. Further, they will develop and deliver education to healthcare providers in the use of evidence-based screening tools and appropriate early intervention resources to increase their competence level in diagnosis and treatment of childhood developmental and mental health disorders.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	84	84	85	85	86

Annual Indicator	83.1	79.5	82.8	78.9	78.9
Numerator	402	380	434	412	412
Denominator	484	478	524	522	522
Data Source				Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86	87	87	87	87

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Birth certificate (resident instate births) data, 2008, Bureau of Public Health Informatics, KDHE

Kansas's level III hospitals are HCA Wesley Medical Center (Wichita), Via Christi-St. Joseph, (Wichita), Stormont-Vail Regional Medical Center (Topeka), HCA Overland Park Medical Center (Overland Park), Shawnee Mission Medical Center (Merrian) and Kansas Bell Memorial Hospital (Kansas City).

Notes - 2007
Data Source: Birth certificate (resident instate births) data, 2007, Center for Health & Environmental Statistics, KDHE

Kansas's level III hospitals are HCA Wesley Medical Center (Wichita), Via Christi-St. Joseph, (Wichita), Stormont-Vail Regional Medical Center (Topeka), HCA Overland Park Medical Center (Overland Park), Shawnee Mission Medical Center (Merrian) and Kansas Bell Memorial Hospital (Kansas City).

a. Last Year's Accomplishments
In 2008, the percent of very low birth weight (VLBW) infants delivered in subspecialty perinatal care facilities was 78.9%, a 4.7% decrease from 2007 (82.8%). This decrease was not statistically significant. Over the ten year period (1999-2008), there was a slight increasing trend detected in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. The annual percent change was not significant (0.58).

Direct Services:

Services were provided in subspecialty perinatal care facilities in the Wichita, Topeka and Kansas City metropolitan areas.

Enabling Services:

Obstetrical providers in the public and private sectors utilized a variety of methods to identify women at risk for preterm delivery or other complications that potentially lead to the delivery of

very low birthweight infants.

Population Based Services:

MCH grantee staff provided education to pregnant women on the warning signs of premature labor along with instructions about what to do if they experience any of the signs of early labor.

Infrastructure Building Services:

KDHE combined the Kansas Perinatal Council (KPC) and Kansas Child Adolescent Health Council (KCAHC) multidisciplinary groups of MCH expert advisors into a single advisory council, the Kansas Maternal and Child Health Council (KMCHC).

The Perinatal Association Kansas (PAK), March of Dimes and MCH provided a forum for dialogue about state perinatal health issues and providededucational opportunities to MCH grantees, private providers and hospitals on current best practices.

Kansas maintained a provider-driven perinatal referral system that facilitated access to inter-city/county/region consultation between primary obstetrical care providers and specialty maternal-fetal medicine professionals. This system included six hospitals that self-designated as subspecialty perinatal care centers providing out-patient and in-patient high risk obstetrical/fetal and neonatal services: Wesley Medical Center and Via Christi-St. Joseph Campus, Wichita; Stormont-Vail Health Care, Topeka; Overland Park Regional Medical Center, Shawnee Mission Medical Center and the University of Kansas Medical Center in the Kansas City area. Two subspecialty perinatal care centers provided a formalized perinatal transport system to maximize the potential for the delivery of referred high-risk obstetrical cases from outlying communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide workforce educational opportunities in partnership with PAK, KHA, hospitals and other health care providers and a plan to develop and disseminate website and educational materials.		X		X
2. Perinatal outcome data is provided in an electronic format to delivering hospitals who request data about their hospital or hospital group.		X		X
3. Develop protocols for obstetrical case management of maternal transfer and improvement of pre-/interconception health with PAK, hospitals and KHA.		X	X	X
4. Develop map of perinatal care system.				X
5. Provide information to health care providers concerning levels of perinatal health care services available in obstetric care facilities.				X
6. MCH serving as lead partner for Text4baby program in Kansas to get healthy messages out to pregnant women and moms.		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services:

Services are provided in subspecialty perinatal care facilities in metropolitan Wichita, Topeka and Kansas City.

Enabling Services:

Local obstetrical providers utilize many methods to identify women at high risk for preterm delivery or complications that will potentially lead to the delivery of very low birth weight infants.

MCH program is partnering with national Text4baby program to get text messages containing health tips for pregnant women/moms in caring for their babies that is timed to due dates/babies' age up to one year.

Infrastructure Building Services:

The Perinatal Association Kansas (PAK), March of Dimes and MCH provides a forum for dialogue about state perinatal health issues and provides educational opportunities to MCH grantees, private providers and hospitals on current best practices.

The KMCHC meets to address MCH issues requiring expertise from a multidisciplinary advisory council. The perinatal breakout session held during the KMCHC meetings meet to address such issues as: a birth spacing waiver; a review of Women's Right to Know video/legislative language; work on a perinatal strategic plan; discussions of alcohol and substance use during pregnancy; effect of H1N1 Pandemic Influenza on pregnancy; work on maternal mortality review process and preterm births and infant mortality.

Requesting hospitals have been provided perinatal outcome information/data for their hospital or hospital group by using an electronic format.

c. Plan for the Coming Year

Direct Services:

Services will continue to be provided in subspecialty perinatal care facilities in Wichita, Topeka and Kansas City.

Enabling Services:

Work will continue with perinatal health care stakeholders on the items listed in Current Activities section.

Population Based Services:

MCH will develop website resources and disseminate educational materials to providers of care to pregnant women, information to recognize the signs of preterm labor, and other high-risk obstetrical conditions with instructions to seek immediate obstetrical care.

MCH will assist PAK to make a concerted effort to provide professional education and consultation to obstetrical delivery facilities and advocate for delivery of very low birthweight infants in subspecialty perinatal care facilities.

Infrastructure Building Services:

The MCH program will continue to partner with the national Text4baby program to get text messages containing health tips for pregnant women and moms in caring for their babies that is

timed to due dates or babies' age up to one year.

MCH staff will continue all of the items listed in the Current Activities section.

MCH will pursue increasing active participation from the Kansas Hospital Association when discussing plans to enhance perinatal health outcomes through increased hospital education and policy development.

MCH will provide health care providers information on the level of perinatal care services each obstetric facility provides on an as-needed basis. Kansas obstetric facilities self-designate the level of perinatal care services provided.

MCH staff will continue work on developing a map of the Kansas perinatal health system.

MCH plans to provide a more in-depth analysis of the statistics related to VLBW infants in terms of delivering hospital, maternal and infant transport, the effects of race and ethnicity, access to health care and infant outcomes to help guide policy development in this area.

KDHE will continue to provide perinatal outcome data to hospitals using an electronic format.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88	89	78	78	79
Annual Indicator	76.0	75.0	72.4	73.1	73.1
Numerator	27687	28286	28677	29089	29089
Denominator	36430	37733	39597	39776	39776
Data Source				Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2008
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	79	80	80	80	80

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Birth certificate (resident) data, 2008, Bureau of Public Health Informatics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2007

Data Source: Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

a. Last Year's Accomplishments
In 2008, 73.1% of infants were born to pregnant women receiving prenatal care in the first trimester, a 1.0% increase from 2007 (72.4%). This increase was statistically significant ($p<0.05$). The U.S. data for 2006 (the latest data available) on this performance measure was 69.0%. Kansas exceeded the U.S. on this measure by 8.7% in 2006 (75.0%). Over the three year period (2005-2008), there was a decreasing trend detected. The annual percent change was not significant (-1.51).

Direct Services:

In 2008, 87 MCH grants were awarded covering 101 counties and served 10,042 mothers and infants who received prenatal care/care coordination, postpartum and infant health services. Eight agencies continued to provide medical prenatal care due to lack of available providers in their communities.

Enabling Services:

In 2008, Healthy Start Home Visitors (HSHV) provided education, support and referrals to community services for 7,290 women during 11,320 outreach visits. Information on breastfeeding, improving oral health for families and a five-minute video from the WIC program regarding infant latch-on was provided to home visitation staff. The HSHV encouraged use of the toll-free, Make A Difference Network (MADIN) number that provides pregnant women information about community resources.

Funding continued from the Kansas Medicaid program for providers in high-risk communities for "Healthy Babies Initiatives" that provide extra case management and care coordination for pregnant women enrolled in Medicaid.

MCH staff continued collaboration with the Farm Worker Health Program to help assure outreach and access to prenatal care services for a mostly Hispanic migrant population whose primary languages are Low German or Spanish.

Population Based Services:

MCH staff continued to identify women at risk for late entry and/or no prenatal care in coordination with the
WIC, MCH, and Family Planning programs. MCH program staff continued an educational partnership with the March of Dimes (MOD) to disseminate information on perinatal health care topics with a focus on the importance of early prenatal care and prevention of premature delivery.

Infrastructure Building Services:

MCH staff provided technical assistance to MCH grantees in developing and continuing translation services and print materials primarily in Spanish for the increasing Hispanic population in Kansas to encourage them to seek early prenatal care. MCH program staff continued collaboration with the MOD, the Juvenile Justice Authority, Pregnancy Maintenance Initiative projects, Federally Qualified Health Centers and Comprehensive School Health Centers to encourage early and regular prenatal care for all pregnant women. Workforce development and training were provided during the fourth annual Governor's Conference on Public Health.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide Prenatal Care/Care Coordination Services.	X		X	
2. Identify women at risk for late entry or no prenatal care.		X	X	
3. Partner with March of Dimes Prematurity Campaign by educating on signs of premature labor.				X
4. Utilize prenatal, delivery and postnatal provider databases.		X		X
5. Provide/encourage use of toll-free MADIN line.		X		
6. Encourage greater use of readily available data systems (e.g., KIC, Vital Stats, etc.,).				X
7. Promote early and comprehensive prenatal health care through all available means.		X	X	X
8. Promote optimal health during the interconception period.			X	X
9. Support/encourage local efforts to overcome disparities in the provision of prenatal care and incidence of low birth weight.		X		
10. Work with KDHE Center for Health Disparities on messaging related to healthy pregnancy information to various cultures in Kansas.			X	X

b. Current Activities

Direct Services:

Care coordination and case management are used locally by MCH agencies to provide prenatal services. Maintain the number of clinics providing this type of service delivery in 2010.

Enabling Services:

MCH staff supports local education/outreach strategies providing resources to improve access to comprehensive prenatal care services. Wyandotte County collaborates in a system of prenatal care services with area hospitals/obstetrical providers. Healthy Babies in Sedgwick County uses a nurse case management model to provide high-risk families information/support.

Population Based Services:

MCH program serves as lead partner for Kansas in the national Text4baby program providing free text messages containing health tips for pregnant women and moms caring for babies timed to due dates or babies' age up to one year.

Prenatal outreach is coordinated with Family Planning, WIC and MCH offering assistance in navigating the healthcare system and completing client paperwork.

Infrastructure Building Services:

MCH collaborates with the Perinatal Association of Kansas (PAK), the Kansas Health Policy Authority, MOD and others in identifying/promoting best perinatal practice strategies.

MCH provides technical assistance/training to local communities in use of available data determining/addressing community needs for prenatal care.

MCH uses a perinatal health care/local breastfeeding service providers database to provide stakeholders information on available resources/information.

c. Plan for the Coming Year

Direct Services:

Care coordination will continue through MCH grants to local agencies from KDHE. Also, the provision of medical prenatal services will continue in some communities to address gaps in provider services.

Enabling Services:

MCH will continue to provide local agencies technical assistance in service provision and assist in finding resources.

MCH program staff will continue to foster relationships among perinatal healthcare providers, State agencies, businesses, the health insurance industry and other interested partners.

MCH, WIC and MOD will continue to work with Healthy Babies in Wichita and support efforts of the Connections Program in Wyandotte County that assists private providers in providing services to large numbers of uninsured.

Population Based Services:

MCH program will serve as lead partner for Kansas in the national Text4baby program that provides free text messages containing health tips and other information for pregnant women and moms caring for babies timed to due dates or the babies' age up to one year.

Promote MCH issues to the public and providers through use of billboards, social media and web pages with health information and links to reliable health information regarding pregnancy, childbirth, infant care and other women's and family health topics.

Promote the engagement of fathers in taking more active roles in supporting healthy pregnancy, childbirth and infant care through education during the annual Parent Leadership Conference.

Early prenatal care outreach will continue through coordination with Family Planning and WIC service providers and the MCH Program. Local MCH grantees will continue education and outreach strategies with guidance and support from MCH program staff.

Infrastructure Building Services:

In order to maximize resources, MCH will continue to build on collaborations with current partners and local obstetrical and perinatal health care providers in order to maximize resources. Support will be provided to programs designed to promote and assure access to early and comprehensive prenatal care and to promote optimal health in the interconception period.

Work with KDHE Center for Health Disparities on identifying issues related to access and promotion of healthy pregnancy information in various cultures in Kansas.

MCH staff will continue workforce development efforts and training through the annual Governor's Conference on Public Health and regional home visitation training events.

MCH program staff will disseminate best practice information through the perinatal healthcare provider database and provide information from the breastfeeding resources database to interested health care providers.

MCH program staff will provide linkages to best practices and available trainings on promoting healthy birth outcomes among disparate populations and give technical assistance to local agencies.

D. State Performance Measures

State Performance Measure 1: *The percent of women in their reproductive years with public or private health insurance coverage*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		90	90	90	90
Annual Indicator	81.8	80.3	82.7	82.0	82.0
Numerator	416378	401212	414017	404860	404860
Denominator	509019	499641	500651	493769	493769
Data Source				Kansas BRFSS, 2008	Kansas BRFSS, 2008
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Source: Kansas Behavioral Factor Surveillance Survey, 2008

Notes - 2007
Source: Kansas Behavioral Factor Surveillance Survey, 2007

a. Last Year's Accomplishments
Elimination of health risks and comprehensive management of disease prior to pregnancy increase the likelihood of a pregnant woman delivering a healthy infant. Access to health services that include preventive, primary care and tertiary care often depends on whether a person has health insurance. In 2008, the percent of Kansas women ages 18-44 that reported they have health insurance was 82.0%, a 0.8% decrease from 2007 (82.7%). This compares to 80.7% for the U.S. From 2002 to 2008, there is a slightly decreasing trend in the percent of women ages 18-44 who reported having health insurance. The annual percent change was not significant (-0.5).

Direct Services:

Women were assisted in completing application documents for Medicaid and HealthWave (SCHIP) programs by health department staff, Supplemental Nutrition Program for Women, Infants and Children (WIC) staff, school nurses, and home visitation staff.

Enabling Services:

The Kansas Statewide Farmworker Health Program (SFHP) provided outreach and assisted with access to health care for the predominately Hispanic and Low German speaking farm worker population with no insurance.

Healthy Start Home Visitors (HSHV's) supported families by providing information on local resources and assistance in filling out forms for medical services and public assistance.

Population Based Services:

UniCare and Mercy Family Health Partners together administered the managed care programs consisting of HealthWave (Kansas SCHIP). UniCare offered a free service, Maternicall, which allowed pregnant women access to critical prenatal care information to promote healthier pregnancies and birth outcomes provided by a healthcare team led by specially trained Registered Nurses.

Infrastructure Building Services:

The MCH program with its network of statewide partners continued to work toward the priority of comprehensive health care for pregnant women before, during and after birth that was identified in the MCH 2010 Statewide Needs Assessment.

March of Dimes continues to be a major partner in supporting MCH priorities as identified above through programs, outreach and advocacy efforts.

Continue surveillance of the health insurance status of women of reproductive age as an predictor of birth outcome data for the State.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate information on the availability of Medicaid/HealthWave coverage for pregnant women.		X	X	X
2. Promote the importance of preventive health care, comprehensive chronic disease management, and early prenatal care for women in the preconception period.		X	X	X
3. Increase efforts to assist uninsured women to enroll in Medicaid/HealthWave.	X	X	X	X
4. Teach adolescents the importance of reducing risk behaviors of smoking, drinking and other physically harmful lifestyles prior to pregnancy.			X	X
5. Provide outreach and education to hard to reach populations and disparate populations.			X	X
6. Promote health insurance coverage availability for all women of childbearing age in the State.				X
7. Work toward obtaining birth spacing waiver.				X
8. Healthy mother and babies programs address high-risk disparate populations.		X		
9. KDHE serves as lead partner for Text4baby program in Kansas to get healthy messages out to pregnant women and moms.		X	X	X
10.				

b. Current Activities
Direct Services:

LHD staff assists women in completing applications for medical assistance programs.

Enabling Services:

The SFHP offers outreach and access to health care for mainly Hispanic and Low German speaking farm workers.

HSHV's provide links to local services for families and assist them in navigating the health care system.

Comprehensive care coordination programs for women and infants are undertaken in both Wyandotte and Sedgwick Counties. Wyandotte County's Connections program primarily focuses on prenatal care whereas the Sedgwick County Healthy Babies program supports both prenatal care topics and other family support services for high-risk families.

Population Based Services:

The Maternicall program through UniCare provides prenatal care information to pregnant women in the Medicaid managed care system.

Infrastructure Building Services:

Surveillance of early and comprehensive prenatal care for women using Behavior Risk Factor Surveillance System (BRFSS) and other data as appropriate.

MCH staff provides to its local agencies the links to information on best practices and funding resources.

KDHE is partnering with national Text4baby program to get free text messages to enrolled women's cell phones containing health tips for pregnant women and moms in caring for their babies. Messages are timed to due dates or babies' age up to one year and disseminate information on other public health issues to its statewide network of partners via multiple communication channels.

c. Plan for the Coming Year

Due to recent changes in health insurance coverage resulting from the passage of the Patient Protection and Affordable Care Act of 2010 and the selection of new MCH priorities resulting from our most recent State MCH needs assessment, this state performance measure has been discontinued and emphasis will be focused toward improving the percent of women in their reproductive years with adequate information and supports to make sound decisions about their health care.

State Performance Measure 2: *The percent of women who report cigarette smoking during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		11	16	16	15.8
Annual Indicator	16.3	16.5	16.1	16.1	16.1
Numerator	6475	6729	6767	6718	6718
Denominator	39701	40896	41951	41815	41815
Data Source				Kansas Vital Statistics, 2008	Kansas Vital Statistics, 2008

Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15.5	15.3	15.3	15.3	

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Birth certificate (resident) data, 2008, Bureau of Public Health Informatics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Center for Health & Environmental Statistics, KDHE

Data prior to 2005 are not comparable due to the revision of the Kansas Birth Certificate.

a. Last Year's Accomplishments
Cigarette smoking during pregnancy adversely affects the health of both mother and child. It increases the risk for adverse maternal conditions and poor pregnancy outcomes. Infants born to mothers who smoke weigh less than other infants, and low birth weight (<2,500 grams) is a key predictor for infant mortality. In 2008, 16.1% (6,718) of women reported smoking during pregnancy, the same as 2007 (16.1%). Among women that reported smoking during the pregnancy, 52.7% reported Medicaid as principal source of payment for this delivery, a 4.8% increase from 2007 (50.3%). Over the four year period (2005-2007), there was no significantly increasing or decreasing trend detected.

Direct Services:

Tobacco cessation assistance was provided to pregnant women referred to the Kansas Tobacco Quitline (Quitline) and through local tobacco cessation clinical provider services.

Enabling Services:

MCH grantee prenatal care coordinators were encouraged to assess all pregnant women for tobacco use and provide education on the risks associated with continued tobacco smoking and either provided services or referred them to services to aid in tobacco cessation.

Population Based Services:

MCH staff encouraged grantees and partners to pursue available tobacco cessation training, provide smoking cessation opportunities to pregnant women and refer them to the Quitline for follow-up support services.

Infrastructure Building Services:

MCH grantees and other prenatal providers were encouraged to use web resources provided by the National Partnership to Help Pregnant Smokers Quit.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Encourage tobacco cessation training by all prenatal service providers.		X	X	X
2. Provide relevant tobacco cessation materials and resources to local agencies.		X	X	X
3. Educate and encourage all pregnant women who smoke to discontinue smoking during pregnancy.	X		X	X
4. Prevent smoking behavior in preconceptional women and adolescents.	X		X	X
5. Use 5A's Smoking Cessation method with added support from the Quitline as a standard protocol for all MCH grantee providers of prenatal service to women who smoke.			X	X
6. Collect and analyze smoking data from all MCH grantees.			X	X
7. Provide technical assistance on billing to develop program sustainability.				X
8. Monitor relevant tobacco/smoking ordinances and legislation with other KDHE staff and partnering tobacco-free coalitions.				X
9. Kansas enacted smoke free legislation in 2010 session.				X
10.				

b. Current Activities
Direct Services:

Tobacco cessation assistance is provided to pregnant women referred to Quitline and through local tobacco cessation clinical provider services.

Enabling Services:

Prenatal care providers and MCH grantee agencies are given relevant tobacco cessation information/resources through newsletter articles and in other communications.

MCH local agencies provide information on available community resources for smoking cessation to pregnant women and members of their households.

Population Based Services:

MCH prenatal care coordinators provide screening, counseling and referral to the Quitline or local tobacco cessation services for pregnant women. Also, LHD staff report birth outcome and health risk behavior data (smoking) as measures of program performance.

Infrastructure Building Services:

MCH staff and the Kansas Tobacco Use Prevention Program (TUPP) encourage local agencies to refer pregnant women to the Quitline and other tobacco cessation materials.

The Kansas TUPP provides updates to interested stakeholders evaluating the efforts of participating organizations implementing the 5 A's approach and on many other tobacco related issues.

MCH grantees and other prenatal providers are encouraged to use web resources provided by the National Partnership to Help Pregnant Smokers Quit.

Kansas passed a law that makes almost all workplaces, restaurants and bars smoke free with an exception for casino floors in the 2010 legislative session that goes into effect July 1, 2010.

c. Plan for the Coming Year
Direct Services:

Tobacco cessation assistance will continue to be provided to pregnant women utilizing the 5A's Tobacco Use prevention method through local tobacco cessation clinical provider services and via referral to the Quitline.

Enabling Services:

Local prenatal care providers and MCH programs will continue to receive relevant tobacco cessation information/resources via newsletter articles and routine communications from MCH Program staff.

LHD's and other prenatal providers will be encouraged to use web resources provided by the National Partnership to Help Pregnant Smokers Quit.

Home visitation staff will assist families in accessing available community tobacco cessation resources to address this issue.

MCH Program staff will continue to require local agency staff to screen all pregnant women for smoking behavior and tobacco use and provide education on the health risks to mother and infant associated with continued smoking and to make referrals to local tobacco cessation services or the Quitline.

Population Based Services:

MCH programs will be encouraged and assisted to implement systematic changes in their clinics to address tobacco cessation and provide data on their progress.

Infrastructure Building Services:

MCH staff will continue to engage prenatal providers and safety net clinics to include tobacco cessation activities for pregnant women utilizing the capacity in place to provide smoking cessation counseling and referral by prenatal service providers in the state.

MCH staff will monitor data related to smoking behaviors and tobacco use.

MCH staff will provide technical assistance to local grantee agencies regarding billing for tobacco cessation counseling in an effort to support sustainability. Currently Medicaid does not pay for tobacco cessation counseling. Medicaid does pay for the Zyban and Chantix patch, but does not pay for the gum, spray, inhaler, or lozenge.

MCH staff will work with Kansas Health Policy Authority staff for Medicaid reimbursement for tobacco cessation counseling which currently is not reimbursed in Kansas.

MCH staff will continue to work with local, regional and state-level stakeholder organizations to implement prenatal smoking cessation activities in public and private venues.

MCH staff will be supportive of any new environmental smoke-free legislation and tobacco taxation proposed.

State Performance Measure 3: *The percent of mothers who breastfeed their infants at least 6 months*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		25	26	27	50
Annual Indicator	37.8	42.3	42.1	43.8	43.8
Numerator					
Denominator					
Data Source				National Immunization Survey, 2006 births	National Immunization Survey, 2006 births
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	

Notes - 2009
The 2009 column is populated with 2008 data.

Notes - 2008
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Provisional geographic-specific breastfeeding rates among children born in 2006, CDC's Breastfeeding National Immunization Data: Any by States: 2006.

http://www.cdc.gov/breastfeeding/data/NIS_data/2006/state_any.htm

Notes - 2007
Data Source: National Immunization Survey, Centers for Disease Control and Prevention, Department of Health and Human Services.

Final geographic-specific breastfeeding rates among children born in 2005, CDC's Breastfeeding National Immunization Data: Any by States: 2005.

http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm

a. Last Year's Accomplishments
In National Immunization Survey, 43.8% of Kansas children born in 2006 (provisional) were breastfed at least 6 months, 2.5% higher than children born in 2005 (42.1%). This compared to 43.4% for U.S children born in 2006. This estimate was getting closer to, but remained below the national Health People 2010 (HP2010) objective (50%). Over the 7-year period (2000-2006), there was a significantly increasing trend ($p<0.05$) in the percents of Kansas infants breastfed at 6 months of age. The survey showd that low income mothers are less likely to breastfeed than their higher income counterparts.

According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assesses weight status of children from low-income families (below 185% of poverty level) participating in WIC, 20.6% of Kansas WIC infants were breastfed at least 6 months, 4.6 % lower than in 2007 (21.6%). This was 23.4% lower than the percent for U.S. WIC infants (25.4%) and was well below the HP 2010 objective. Over the 5-year period (2004-2008), there is statistically significant decreasing trend in the percents of Kansas WIC infants breastfed at 6 months of age.

Enabling Services:

Kansas Breastfeeding Coalition in partnership with KDHE implemented the Business Case for Breastfeeding grant through workshops and assistance offered to businesses throughout Kansas and billboards in three prominent locations along the Kansas Turnpike and other busy Kansas highways.

Designed and disseminated the "Mother's and Baby's First Weeks Log" and staff "Breastfeeding Evaluation Tool" to all local health departments and school nurses.

Population Based Services:

Supported Breastfeeding Peer Counselor Programs in 19 Kansas counties. Peer counseling was a significant factor in improving breastfeeding initiation and duration rates among women in a variety of settings, including economically disadvantaged and WIC populations.

Coordinate a public awareness campaign for World Breastfeeding Week in August 2009. Provide all clinics who submit a summary of their activity with up to $75 worth of breastfeeding education and/or resource materials.

Infrastructure Building Services:

Facilitated discussion of LHD staff in two counties to evaluate and develop breastfeeding strategies. Staff from a variety of programs within the LHD attended.

Presented information on the benefits of breastfeeding to the Perinatal Council of Kansas.

Supported Certified Breastfeeding Educator Training in October 2008.

Provided financial support to the Kansas LaLeche League 2009 spring continuing education conference for all health professionals.

Quarterly breastfeeding packets including a newsletter to share with other health professionals and new breastfeeding resources were distributed to 104 locations throughout the state.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Support community breastfeeding coalitions by encouraging local health departments (LHD) to play an active role.		X		
2. Communicate breastfeeding information to a variety of state and community agencies.				X
3. Disseminate breastfeeding newsletter for LHDs to send to community contacts.			X	
4. Support LHDs through WIC and MCH to continue and implement breastfeeding friendly policies.				X
5. Increase breastfeeding knowledge of LHD staff for both MCH and WIC programs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Enabling Services:

Support evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets will include a newsletter and breastfeeding resources which can be shared with other health professionals in their communities.

Support growth of Breastfeeding Peer Counselor programs in 16 additional counties.

Population Based Services:

Ongoing training and partnerships including the Business Case for Breastfeeding to support working breastfeeding mothers.

Coordinate a public awareness campaign for World Breastfeeding Week in August 2010. Provide $200.00 worth of breastfeeding education and/or resource materials to 2 clinics with the most innovative implementation of the World Breastfeeding Week theme.

Infrastructure Building Services:

The Kansas WIC Program plans to hire a public health nurse to coordinate the Breastfeeding Peer Counselor Program.

Breastfeeding data from the Kansas Live Birth Certificate are not yet available. Information on the importance of collecting breastfeeding information and the benefits of breastfeeding will be sent to hospitals identified as submitting incomplete certificates.

Providing the "Using Loving Support to Grow and Glow in WIC Breastfeeding" training to all Kansas WIC staff. Trainings are open to all other LHD staff who work with breastfeeding women.

Support Certified Breastfeeding Educator Training in October 2009 and June 2010.

c. Plan for the Coming Year
Enabling Services:

Support evidenced-based breastfeeding related training of researchers and practitioners by distributing breastfeeding packets throughout the state. The packets will include a newsletter and breastfeeding resources which can be shared with other health professionals in their communities.

Support growth of Breastfeeding Peer Counselor programs in additional counties.

Population Based Services:

Work with local Breastfeeding Coalitions, the LaLeche and other interested parties to promote breastfeeding friendly employee policies.

Support World Breastfeeding Week activities.

Infrastructure Building Services:

Work with LHD to improve the clinic atmosphere to support breastfeeding dyads through local needs assessment and policy development.

Work with LHD to improve staff competencies related to breastfeeding, including helping to sponsor Certified Breastfeeding Educator Training in at least one location.

Provided financial support to the Kansas LaLeche League continuing education conference for all health professionals.

Support at least one Certified Breastfeeding Educator Training.

State Performance Measure 4: *The percent of children and adolescents that receive behavioral/mental health services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		6	7	7	8
Annual Indicator	5.0	5.4	6.0	6.2	6.5
Numerator	41701	46970	51407	53426	56032
Denominator	842406	862298	861972	866810	866810
Data Source				Kansas Community Health Centers	Kansas Community Health Centers
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	8	8	

Notes - 2009
Data Source: Kansas Community Health Centers, 2009 (ages 0-21)(Provisional data)

Notes - 2008
Data Source: Kansas Community Health Centers, 2008 (ages 0-21)

Notes - 2007
Data Source: Kansas Community Health Centers, 2007 (ages 0-21)

a. Last Year's Accomplishments
In 2008, the percent of children and adolescents (ages 0-21) that received behavioral/mental health services at community mental health centers (CMHCs) in Kansas was 6.2%, a 3.3% increase from 2007 (6.0%). During 2004-2008 there was an increasing trend detected with the annual percent change (6.6) considered significant. The primary reason for the increase in youth enrolled in mental health services was tied a goal of the Kansas public mental health system provide outreach and mental health services for children with a serious emotional disturbance (SED). It was estimated that about 20 percent of children nationwide have mental disorders that resulted in at least a mild functional impairment. It was also estimated that approximately 5 to 9 percent of children and adolescents ages 9 to 17 experienced the more severe functional mental health limitations of SED. Based on this information, it was estimated that 29,000 to 52,300 children/adolescents in Kansas suffered from a SED. During 2009 the Kansas CMHC served 23,053 youth in the SED population, roughly 40% of all youth with an open admission during the same time. The number of SED youth served steadily increased each year and contributed to the overall increase in the number of youth served in the public mental health system.

Kansas has trend data from the Youth Risk Behavior Survey (YRBS). School failure, substance abuse, violence, and suicide were potential outcomes of mental and behavioral disorders and SED. Kansas YRBS data identified risk factors based on specific time frames. In the "during the past 30 days" time frame, students who smoked cigarettes was 21.0% in 2005 compared to 20.6% in 2007; 43.9% of students drank alcohol in 2005 compared to 42.4% in 2007; and 15.6% used marijuana in 2005 compared to 15.3% in 2007.

Other questions revealed that 6.0% used Ecstasy one or more times during their life in 2005 compared to 8.6% in 2007; 21.4% of students felt so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities during the 12 months in 2005 compared to 25.0% in 2007; and 6.5% attempted suicide during the past 12 months in 2005 compared to 6.7% in 2007.

Direct Services:

Kansas continued to use the telemedicine network from Kansas University Medical Center (KUMC) connecting students to mental health counseling with age-appropriate psychiatrist.

Enabling Services:

MCH adolescent health staff was a member of the Governor's Mental Health Services Planning Council (GMHSPC). The Council distributed and promoted the Kansas state-wide mental health plan though web-based newsletters and conference booths.

Population Based Services:

KDHE partnered with Kansas State Department of Education (KSDE) offering an Adolescent Health Symposium attended by sixty teachers and school nurses. The speakers addressed adolescent behavioral and emotional issues and provided information about strategies implemented by schools across the country to address the issue.

Students Against Destructive Decisions (SADD) Kansas Chapter provided 15 teams of SADD youth a three-day leadership training and followed-up with a recognition banquet later in the year.

The Annual Statewide Conference for Kansas School Nurses provided education on working with difficult children.

Infrastructure Building Services:

MCH adolescent health staff is a member of the Governor's Mental Health Services Planning Council subcommittee. The subcommittee submitted a grant that was not funded and thus, continued seek funding for implementation of the State mental health plan.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen all children for behavioral/mental health issues at Kan-Be-Healthy visits conducted in MCH clinics.	X	X	X	X
2. Provide workforce development opportunities on mental health screening and early detection to local MCH grantees, school nurses, parent groups, and other KDHE programs through educational opportunities and conferences.		X	X	X
3. Create awareness of usable tools for screening and guidance		X	X	X

available in Bright Futures Mental Health for providers in Kansas.				
4. Participate in the Governor's Mental Health Services Planning Committee and disseminate the State Mental Health Plan for Kansas.		X	X	X
5. Continue collaboration and communication between KDHE, SRS and GMHSPC to maximize limited funding.				X
6. Provide education for school nurses and MCH grantees on working with clients with mental illness and making appropriate referrals.		X	X	X
7. Prepare youth to engage the community promoting principles of the Students Against Destructive Decisions (SADD) organizations.		X	X	X
8. Work with Coordinated School Health Services and KSDE to provide a Symposium on Adolescent Health Issues.		X	X	X
9.				
10.				

b. Current Activities
Direct Services:

School-based clinics provide individual/family therapy counseling through the regional mental health centers and KUMC telemedicine.

KVC Wheatland Psychiatric Hospital in Hays, Kansas, opened its doors in 2010 and accommodates children and adolescents in western Kansas.

Enabling Services:

KDHE adolescent health staff is a member of the Kansas Child Welfare Quality Improvement Council (KCWQIC), a Social and Rehabilitative Serviced (SRS) advisory committee for children in foster care/children receiving Medicaid. A priority for the committe is inclusion of fathers in case planning and assessing father/child physical/emotional needs.

Population-Based Services:

KDHE partnered with KSDE to offer an Adolescent Health Symposium.

Students Against Destructive Decisions (SADD) Kansas Chapter provided SADD youth a three-day leadership training and then followed-up with a recognition banquet later in the year.

Infrastructure Building Services:

KDHE adolescent staff continues participation on the GMHSPC subcommittee.

The Kansas Chapter, American Academy of Pediatrics (KAAP) and the KDHE MCH staff convened a multi-agency task force to ultimately increase mental health screening.

c. Plan for the Coming Year
This State Performance Measure is discontinued for SFY 2011.

State Performance Measure 5: *The percent of children who are overweight*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	12	12	11.5	11.5	11
Annual Indicator	12.9	13.8	13.6	13.3	13.3
Numerator	4306	3092	4281	4569	4569
Denominator	33378	22404	31476	34352	34352
Data Source				Kanas PedNSS, 2008	Kanas PedNSS, 2008
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11	10.5	10.5	10.5	

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Pediatric Nutrition Surveillance System (PedNSS), 2008, Kansas WIC data of children, ages 2-<5 (>=95th percentile), used as a proxy measure.

Notes - 2007
Data Source: Pediatric Nutrition Surveillance System (PedNSS), 2007, Kansas WIC data of children, ages 2-<5 (>=95th percentile), used as a proxy measure.

a. Last Year's Accomplishments
According to the 2008 Pediatric Nutrition Surveillance System (PedNSS), which assessed weight status of children from low-income families (below 185% of poverty level) participating in WIC, 13.3% of low-income children ages 24-59 months in Kansas were obese (above 95%), 10.1% lower than WIC participants nationally (14.8%). There was a increasing trend during 2000-2004 followed by a slight decreasing trend or remained stable since 2004. The Annual Percent changes were significant only for the segment corresponding to 2000-2004 (6.71, -0.05, respectively).

Enabling Services:

Worked with the Office of Health Promotion to promote a statewide event on May 1, 2009. The event focused on increasing physical activity among 3rd grade students.

Training websites and resources that promote good nutrition and physical activity were published in the resources and events section of the Zero to age 21: Information for Promoting for Public Health Professionals working with Kansas Kids (ZIPS) newsletter throughout the year.

Infrastructure Building:

Approximately 85 physical education teachers, school nurses and local or state health department staff attended the 2010 Symposium on Adolescent Health Issues on February 5, 2010. Dr. Amy Cory presented a session titled "Adolescent Obesity: The Sequelae of Overnutrition and Its Relationship to Injury Prevention."

Four state staff attended CDC's Weight of the Nation Conference. An inservice reviewing this conference was provided to all MCH state staff in August 2009.

Three state staff attended the 2009 Annual Meeting of the Association of State and Territorial Public Health Nutrition Directors.

LHDs were encouraged to attend the October 2009 Built Environment summit.

Population Based Service

School nurses were surveyed to assess if school aged children are being weighed, measured and referred, as appropriate. Base line data indicated that approximately 20% of nurses are assessing BMIs. The importance of assessing height, weight and BMI's of school aged children was covered in newsletters and trainings targeting school nurses.

The new WIC Food Packages which provide a cash value check for fresh, frozen or canned fruits and/or vegetables were implemented in Kansas on August 1, 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure access to a food supply and healthy food choices.			X	
2. Assure access to safe, affordable opportunities to be physical active.			X	
3. Identify funding resources and partners.		X	X	
4. Utilize and improve data systems.		X	X	X
5. Use and communicate results of program and policy interventions that contribute to evidence-based strategies.		X		X
6. Increase the number of well-trained MCH personnel who support healthy eating and physical activity.		X		
7. Promote consistent messages with best evidence available.		X	X	
8.				
9.				
10.				

b. Current Activities
Enabling Services:

Continue working with the Office of Health Promotion to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. This event was May 7, 2010.

Participating in Children's Health in All Policies (Chap) Advisory Panel conversations about Policy Options for Addressing Obesity in Kansas Children sponsored by the Kansas Health Institute.

Infrastructure Building:

Assist LHDs in identifying and accessing funding streams that could potentially support nutrition and physical activity programs at the community level and publishing the resources in ZIPS.

Facilitate MCH staff in obtaining continuing education to promote, deliver and evaluate services to support healthy eating and physical activity by encouraging attendance at the 2011 Symposium on Adolescent Health Issues.

Work with the Coordinated School Health program, Blue Cross and Blue Shield Foundation of Kansas, Healthy Kids Kansas and Community Health Assessment to assist communities, child care facilities and schools in obtaining grants for communities to use to address healthy eating and physical activity.
Population Based Service

Survey school nurses to assess if school aged children are being weighed, measured and referred, as appropriate.

Promote increased intake of fruits and vegetables by increasing the amount of fruits and vegetables provided to WIC women.

c. Plan for the Coming Year
Enabling Services:

Model health education and physical activity for 3rd grade students in Kansas, by working with the BHP to promote the Kansas Kids Fitness Day, a statewide event focused on increasing physical activity among 3rd grade students in Kansas. Nearly half of all third graders in the state of Kansas participate each year.

Promote the use of existing online staff educational programs that promote good nutrition and physical activity.

Population Based Service

Survey school nurses to assess if school-aged children are being weighed, measured and referred, as appropriate. Importance of assessing these parameters will be covered in newsletters and trainings.

Work with the Office of Health Promotion and other stakeholders to design and promote a consistent and culturally appropriate nutrition and physical activity messages.

Infrastructure Building:

Assist LHDs in identifying and accessing funding streams that could potentially support nutrition and physical activity programs at the community level.

Strengthen processes and mechanisms to assist LHD in successful grant writing by identifying online training resources and workshops or through support of speakers at public health conferences.

Enhance the socioeconomic development, organization and project management, policy research, and meeting facilitation and data collection and evaluation in state and local programs.

State Performance Measure 6: *The rate of adolescent deaths due to motor vehicle crashes when using no seat belt*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		20	13	12.5	12
Annual Indicator	13.4	14.3	13.9	15.5	15.5
Numerator	27	29	28	31	31
Denominator	201966	202458	201815	199858	199858
Data Source				Fatal Accident Reporting System	Fatal Accident Reporting System
Is the Data Provisional				Final	Provisional

or Final?					
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11.5	11	11	11	

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Summer 2010.

Notes - 2008
Data Source:
Numerator = Fatal Analysis Reporting System (FARS), U.S. Department of Transportation Data. http://www-fars.nhtsa.dot.gov/Main/index.aspx.
Denominator = U.S. Census estimates, Bridged-Race Vintage data

Notes - 2007
Data Source:
Numerator = Fatal Analysis Reporting System (FARS), U.S. Department of Transportation Data. http://www-fars.nhtsa.dot.gov/Main/index.aspx.
Denominator = U.S. Census estimates, Bridged-Race Vintage data set

a. Last Year's Accomplishments
Unintentional injurywas the leading cause of death for Kansas' adolescents ages 15 to 19 in 2008 with motor vehicle crashes (MVC) causing the majority of deaths. According to Kansas FARS (Fatal Accident Reporting System) data, from 1999-2008, overall, there was a decreasing trend detected in deaths due to motor vehicle crashes where the occupant was not wearing a seat belt. The annual percent change was significant (7.9).

In 2008, the adolescent death rate due to motor vehicle accidents without using a seatbelt was 96.1% higher for Kansas (15.5 per 100,000) than for the U.S. (7.9). In Kansas, between 2007 (13.9) and 2008, there was an 11.5% increase in motor vehicle crash deaths where the youth was not wearing a seat belt.

Kansas 2007 YRBS data showed that 15% of high school students never or rarely wore a seat belt. This remained unchanged from 2005. Kansas Department of Transportation (KDOT) data for 2008 showed that 71.4% of teens (ages 15-18) that died because of a motor vehicle crash were not using safety equipment.

Suggested reasons for Kansas' higher MVC rate includes teen drivers did not believe they would be involved in a MVC thus did not buckle up. In the more remote rural areas in Kansas, there was a higher fatality rate than for urban areas possibly because the MVC was not immediately discovered and the emergency response teams may have been several minutes away. The driver's use of alcohol was another factor in motor vehicle related deaths. KDOT data showed that among 131 alcohol-related deaths in 2008, 18 of the deaths occurred with drivers under age 21. The Youth Risk Behavior Survey (2007) indicated that 31% of Kansas students (grades 9-12) reported within the previous 30 days they rode with a driver who had been drinking alcohol and 15% reported they drank alcohol and drove within the previous 30 days.

Enabling Services:

The Annual Statewide Summer Conference for Kansas School Nurses provided a session and information on head and neck injuries to improve survival and morbidity rate. Encouraging adolescents in seat belt usage was a emphasized in this presentation.

The Kansas Family Partnership (KFP) again sponsored the Students Against Destructive Decisions (SADD) chapters and coalition activities as well as the Red Ribbon campaign that enlisted thousands of Kansans to join in the fight against the illegal use of drugs, alcohol and

tobacco. KFP held the Kansas Youth Leadership Summit and activities to educate and change the public's perception that underage drinking is not a "Rite Of Passage." All of these activities incorporated and reinforced responsible use of seat belts along with their messages of about drugs, alcohol, and tobacco.

Population Based Services:

MCH staff worked with Kansas Traffic Safety Resource Office (KTSRO) and the Kansas Highway Patrol, local law enforcement, the Kansas Drivers Safety Education Association, AAA, Kansas Safe Kids Coalitions, the Kansas Family Partnership, SADD and others to provide an assortment of traffic safety education through newsletters, web mail, education programs and public service announcements.

KDHE partnered with Kansas State Department of Education (KSDE) to offer an Adolescent Symposium in which a keynote examined injury and violence trends among American youth and the responses some schools have made to address this problem. Again, traffic deaths were highlighted along with seat belt usage by youth.

Infrastructure Building Services:

KFP spearheaded a successful effort to get a social hosting law passed that made it illegal (with fines) for adults to host adolescents drinking alcohol on their property.

Kansas Trauma Program continued to look at a system to track the cost of follow up care for MVC victims not wearing seat belts by looking at hospital data relating to trauma. Primarily cost data was only available relating to the hospital charges and not the auxiliary services that were billed separately. More data needs to be collected before the system can calculate the actual cost.

MCH staff along with the numerous partner coalitions and agencies supported legislation for a graduate driver's license and primary seat belt law that did not pass.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote seat belt usage by adolescents through support of legislation and local efforts to increase seat belt usage.	X	X	X	X
2. Formulate work plans with State SADD leadership to increase incentives for SADD chapters to promote seat belt use among teens.		X	X	X
3. All providers will discuss seat belt usage as anticipatory guidance with all adolescents receiving a Kan-Be-Healthy services in MCH clinics.		X		X
4. Provide KTSRO and SADD technical assistance resources to school nurses on decreasing MVCs in their communities.			X	X
5. Continue to serve on the advisory board for Leadership to Keep Children Alcohol Free and examine effectiveness of initiatives used across Kansas to decrease drinking and driving.			X	X
6. Write articles on teen seatbelt use for the KDHE and ZIPS newsletters to provide education and resources for promoting seat belt use in communities.			X	X
7. Attend and provide training on strategies to engage teens in decision-making related to safe motor vehicle use, use of seat			X	X

belts, and decreasing risk behaviors that contribute to adolescent deaths.				
8.				
9.				
10.				

b. Current Activities
Enabling Services:

The KSDE continue to administer Safe and Drug-Free Schools and Communities Act Grant Program in 16 schools and community projects. A post conference session at the annual Statewide School Nurse Conference, in partnership with the Kansas Emergency Pediatric Care (EMPC), will provide Emergency Triage Training for school nurses and community.

Population-Based Services:

MCH staff continue to write adolescent health prevention articles that include information regarding seat belt usage for publication in newsletters and listserves for those working with teens.

Infrastructure Building Services:

MCH adolescent health staff continues to work the KSDE regarding program development and promotion of positive decision-making skills in adolescents by supporting the Adolescent Symposium on risky behaviors.

KFP developed a white paper outlining the data and needs of Kansas relating to underage drinking.

MCH continue to collaborate with Kansas EMPC to provide training across Kansas offering rural specific child trauma courses. MCH staff continues to sit on Red Ribbon, SADD, and Leadership to Keep Children Alcohol Free boards in order to promote safer teen driving habits.

The graduated driver's license and primary seat belt usage became law; it also included restrictions on usage of wireless devices while driving.

c. Plan for the Coming Year
This State Performance Measure has been discontinued for SFY 2011 as a result of the changes in our graduated driver's license, primary seat belt law and our most recent State MCH needs assessment. Emphasis will focus on reducing child and adolescent risk behaviors relating to alcohol, tobacco and other drugs.

State Performance Measure 7: *The percent of infants with special health care needs who receive care within a medical home*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		65	65	85	88
Annual Indicator	58.9	58.9	82.1	87	87
Numerator					

Denominator					
Data Source				KS CSHCN infant survey 2008	KS CSHCN infant survey 2008
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	89	91	92	92	

Notes - 2009
DATA SOURCE: Data is based on returned surveys mailed to families identified by the Kansas Vital Records as having birth defects and requested further information from the Bureau of Family Health. Data prior to 2007 is not comparable because of differences in data sources and methods.

NOTE* Data for 2009 is not available. This field was pre-populated with data from 2008.

Notes - 2008
DATA SOURCE: Data is based on returned surveys mailed to families identified by the Kansas Vital Records as having birth defects and requested further information from the Bureau of Family Health. Data prior to 2007 is not comparable because of differences in data sources and methods.

Notes - 2007
Data Source: Survey from families with high risk infants using the vital export file, October 2007 - July 2008. Data prior to 2007 are not comparable due to differences in data source

a. Last Year's Accomplishments
Direct Services:

Contracts required that specialty evaluations and recommendations were sent to the primary care provider within 2 weeks after appointments. The postcards generated from the birth defect registry were discontinued in December 2008 due to low return rate and evidence that supported families were being referred to medical homes and community services at time of discharge.

Enabling Services:

Breakout sessions at family organizations were conducted to educate and build family and young adult's skills to be effective in partnering with providers and assuming a more active responsibility for their "life choices" and health care. Articles addressing families and youth empowerment and how to engage youth in decision making were included in the CYSHCN Magazine available in clinic waiting rooms and for distribution at conferences and through partnerships.

Population Based Services:

Many CYSHCN brochures, websites and other materials were available in English and Spanish. Alternative formats and languages were accomodated upon request.

Infrastructure Building Services:

Participated in the state-level, multi-agency Medical Home Initiative. Family/youth/professional partnerships and increasing access and services received within a Medical Home were two grant objectives of the HRSA D-70 Integrated Community Systems for Youth with Special Health Care Needs grant awarded to Kansas in June 2009. Grant and program efforts were supportive of coordination and collaboration with other programs that had Medical Home initiatives.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medical specialty reports are provided to the PCP and other providers identified by the family.	X			
2. CYSCHN authorizes follow-up services within the medical home related to the eligible health conditions.	X			
3. Contracting PCP can access the state-wide immunization registry.				X
4. CYSHCN tracks medical home status of clients seen in specialty clinics and assists families to obtain a PCP.		X		
5. Infants identified with a positive New Born Screening test are referred to CYSHCN program. Access to follow-up services are explained to families.		X	X	
6. Goals of the D-70 grant include: addressing access to and services received within a medical home, strengthening youth/family/professional partnerships, and supporting health care transition planning within the medical home.			X	X
7. Develop informational materials and promote full inclusion of the medical home elements as HIT/HET are being implemented.				X
8.				
9.				
10.				

b. Current Activities

Direct Services:

Same as 2009. Outcome data from the family and physician survey was shared with providers to better coordinate services between primary and specialty clinics.

Enabling Services:

Kansas Health Policy Authority Medical Home Initiative was given a lower priority due to budgetary cutbacks in July 2009. The CYSHCN program, through the HRSA D-70 Integrated Community Systems grant, began rebuilding Medical Home Initiative interest assuming a greater leadership role identifying champions and networking with other programs.

Population Based Services:

A recent collaboration with the Heartland Genetics Collaborative and other D-70 grantees to develop a regional workgroup who will work to improve transition within the Medical Home for youth with metabolic conditions. Some of the projected outcomes of this group includes developing a "model" for transition within a Medical Home and hosting a multi-state learning event that supports the defragmentation of systems and policies.

Infrastructure Building Services:

Continue to strengthen relationships initiated through the FY 09 State Medical Home initiative addressing concerns with establishing a medical home (impact change on the business model, technology, training, etc.). Through the D-70 grant a funding opportunity was created to encourage pilot projects addressing medical home access.

In February planning for a medical home transition "model" for youth with metabolic conditions started with CYSHCN and D-70 staff leading.

c. Plan for the Coming Year
Direct Services:

Will work with family and youth organizations to develop youth training modules through the D-70 Integrated Community Systems grant on how to partner and communicate with their doctor. CYSHCN will continue contracts with providers for primary and follow up care that can be provided in local communities. CYSHCN clinic staff will continue to assure that specialty clinic notes are sent to the primary care provider within two weeks of the appointment date after receiving parental approval.

Enabling Services:

Continue to expand program and grant e-mail listserves to share effective practice models and promote collaboration and integration of health into partner programs and activities.

Provide support at provider and family conferences through speakers and presentations to attendees. As a contractor with the D-70 grant, the KU Center on Developmental Disabilities will conduct guest lectures to medical and nursing students. Ongoing collaboration with F2F grantee to empower families to take a more active role as a partner with their health care providers.

Contract language supports communication between primary and specialty providers to coordinate care.

Population Based Services:

Incorporate known regional and ethnic data regarding health care access and outcomes in policy and practice changes. Use community brokers to enhance care coordination and address language barriers.

Infrastructure Building Services:

Through the collaboration with the Heartland Genetics Collaborative, CYSHCN and the D-70 grant will present at the Heartland Genetic Fall Conference Kansas' efforts to Medical Home transition. CYSHCN and D-70 staff will be lead agents in the Genetic Transition Taskforce to develop a"model" for youth with metabolic conditions utilizing effective tools already developed to use with the "model".

Continue to network with Medical Home "Champions" and continue to move Kansas medical home initiative forward within CYSHCN capacity.

State Performance Measure 8: *The percent of youths with special health care needs who receive transition services to adult medical care*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		60	60	60	60
Annual Indicator	47.1	47.1	47.1	47.1	47.1
Numerator					
Denominator					
Data Source				National CSHCN	National CSHCN

				2005-2006. est KS	2005-2006. est KS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	65	65	

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006. Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. This measure is derived from several questions that have undergone substantial alterations, additions, and changes in skip pattern. Two questions were removed and several new questions were added to address concepts not measured in 2001 and therefore, this indicator is not comparable with pre 2005 data.

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006. Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. This measure is derived from several questions that have undergone substantial alterations, additions, and changes in skip pattern. Two questions were removed and several new questions were added to address concepts not measured in 2001 and therefore, this indicator is not comparable with pre 2005 data.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06; Percentage of CSHCN (ages 12-17) whose doctors discussed shift to adult provider, if necessary.

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measure. In 2005-06, substantial changes and additions were made to the set of questions and skip patterns used for this outcome. Two questions were removed and several new questions were added to address concepts not measured in 2001. Indicator is not comparable across survey years.

a. Last Year's Accomplishments
Direct Services:

Specialty clinics conducted transition clinics for older youth with special health care needs. Trainings began through the Families Together, Inc. F2F grants with a focus on how to use a personal health care notebook.

Enabling Services:

Families were referred to resources and organizations to determine appropriate levels of guardian support that may be needed for youth with special health care needs. Participation in resource fairs provided opportunities to learn and share community connections to assist in transitioning, not only to adult health care providers, but to address other aspects of work and community

living.

Continued to update the Make A Difference Information Network (MADIN) resource base.

Population Based Services:

Contracts with education and family support organizations resulted in regional transition conferences to educate and inform parents and families about necessary steps for successful transitions. CYSHCN staff participated as attendees, exhibitors and speakers.

Infrastructure Building:

Contract language was strengthened to outline transition planning performance measures in all vendor contracts. CYSHCN continued to serve on advisory councils that addressed youth issues and disability concerns.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Transition clinics for Cystic Fibrosis, Cerebral Palsy, Cleft Lip/Palate and Spinal Cord are held regularly for the older youth.	X	X		
2. Coordinate with family and education partners' transition workshops.			X	X
3. CYSHCN staff participate in local, regional, state and national workshops to promote inclusion and increase awareness of the needs of YSHCN.				X
4. Goal for the D-70 grant to address transition to adulthood, with a focus on health care and health management, by incorporating transition supports for youth and young adults with special health care needs.			X	X
5. CYSHCN staff represents the Secretary of KDHE on the Kansas Commission on Disability Concerns, Kansas Autism Commission, and Kansas Council on Developmental Disabilities.				X
6. Transition information and personal care notebooks are shared with families and providers to support transition planning.		X	X	
7. Family/parent advisory council provides feedback and guidance on current and future transition efforts.			X	X
8.				
9.				
10.				

b. Current Activities
Direct Services:

The Cleft Lip/Palate, Cerebral Palsy, Cystic Fibrosis and Spinal Cord Clinics continue to schedule transition clinics. Adults with eligible genetic conditions are seen in adult specialty clinics.

Enabling Services:

Data is shared with multiple agencies supporting transition services. An advisory council for the D-70 grant was developed and includes parents and youth, representatives from education, disability employment navigators, rehabilitation services, pediatric and adult health, oral and mental health and family and youth advocacy groups.

Population Based Services:

CYSHCN staff serve on the Shared Vision for Youth Council. Data shows that an average of 81-85% of Kansas youth with an IEP are employed or receive higher education one year after graduation. The D-70 grant sponsored four youth to attend the Youth Empowerment Academy's week long Youth Leadership Forum.

Infrastructure Building:

Advisory training sessions provide a broad view of transition issues and encourage stakeholders to think "outside the box" to find opportunities to collaborate.

A computer-based curriculum is being developed to promote self-determination and provide opportunities to learn, practice and master skills necessary for successful transitions. An emphasis is placed on health and wellness, but also includes all aspects of adult life. Supportive technology will be utilized to empower youth to understand and manage their health care needs.

c. Plan for the Coming Year

Direct Services:

Through partnerships with CYSHCN and the D-70 grant, Families Together, Inc. (the F2F grantee) will host regional workshops for youth and families on all aspects of transition. Health and wellness management that emphasizes personal responsibility will be integrated into these transition workshops and conferences.

Continue to support and promote the use of personal health history notebooks, which include sections to help families organize health information such as: health history, emergency preparedness, transition planning and goal setting for adulthood, selecting an adult health care provider, and much more.

Enabling Services:

Develop and disseminate a regional and state-wide resource tool kit and navigational guide to assist youth, family and providers to connect to community/regional resources. Continue to update the MADIN resource base.

Population Based Services:

The computerized curriculum on self-determination and transition planning will be piloted within school systems. The health module curriculum will be piloted first with additional modules for education, employment, and independent living added.

A Youth Advisory Council is being developed to provide the youth voice to the D-70 grant project and CYSHCN program. Youth members will be given opportunities to attend various leadership and advocacy skill building training, work with other youth their age (both locally and across the state), and to participate in a variety of voluntary meetings about specific issues or topics. Youth will be asked to share their experiences and ideas and to help us understand what is needed to improve the transition process for youth and their families.

Infrastructure Building Services:

Continue discussion about common priorities that will support collaborative efforts and integration of systems: duplication of efforts, gaps in service delivery, and stronger youth involvement.

Continue efforts to develop and dissmenate materials to providers, families, youth and partners about key steps towards health care transition and how to incorporate health into other aspects of transition. Through the self-determination curriculum project, use of common technology tools will be used to allow youth increased independence in their health care management.

State Performance Measure 9: *The percent of CSHCN families that experience financial problems due to the child's health needs*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		20	20	20	20
Annual Indicator	21.4	21.4	21.4	21.4	21.4
Numerator					
Denominator					
Data Source				National CSHCN 2005-2006. est KS	National CSHCN 2005-2006. est KS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	20	20	20	

Notes - 2009
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006. Percentage of CSHCN whose conditions cause financial problems for the family.

Data for 2009 is not available. 2005-2006 data was used to pre-populate this performance measure. This indicator is comparable between 2005-2006 and 2001 National Children with Special Health Care Needs Survey.

Notes - 2008
DATA SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs. 2005–2006. Percentage of CSHCN whose conditions cause financial problems for the family.

Data for 2008 is not available. 2005-2006 data was used to pre-populate this performance measure. This indicator is comparable between 2005-2006 and 2001 National Children with Special Health Care Needs Survey.

Notes - 2007
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2005-06; Percentage of CSHCN whose conditions cause financial problems for the family.

The data reported in 2007 are pre-populated with the data from 2005-06 for this performance measures. Indicator is comparable across survey years.

a. Last Year's Accomplishments

Direct Services:

Continued State General Fund budget reductions and level federal funding necessitated increased staff efforts to identify providers, vendors, and hospitals willing to accept our negotiated rate of reimbursement for payment of services and to minimize increased out of pocket expenses for vulnerable families. The insurance status of all families was assessed during multidisciplinary clinics and uninsured families were given information about Medicaid/SCHIP and the CYSHCN program and were encouraged to apply and/or assisted with the CYSHCN application. The CYSHCN program continued to be the sole source of coverage for eligible services and treatment for undocumented residents.

The Make a Difference Information Network (MADIN) provided information and linked families to services.

Enabling Services:

Families that applied for the CYSHCN program were required to apply for the State Medicaid/SCHIP programs unless determined ineligible due to citizenship status during the CYSHCN application process. Families were encouraged to recycle usable medical equipment to the Kansas Equipment Exchange to be refurbished and recycled for the use of other families and to reduce medical equipment budget expenses.

Population Based Services:

Contract performance measures that documented the review of family insurance status were implemented and monitored to ensure families were encouraged to apply for Medicaid/SCHIP and assisted with the CYSHCN application process.

Infrastructure Building Services:

CYSHCN staff ensured that bills for treatment and services to private/public insurance were submitted prior to CYSHCN program payments. CYSHCN contracted providers agreed to accept CYSHCN payments as "payment in full". Additional CYSHCN providers (specialists, primary care providers, pharmacies, and therapists) were added to expand treatment and service options. A Spasticity and Mobility provider/clinic was added to support orthopaedic treatment services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CYSHCN monitors the impact of the expanded Newborn Screening Program on families and our ability to provide treatment formula and services.	X	X	X	
2. Families applying for CYSHCN are required to apply for Medicaid/SCHIP programs.	X	X	X	X
3. CYSHCN collaborates with private organizations and commissions to fund medically necessary treatment, services, and equipment not covered through the program.	X	X	X	X
4. Monitor State and Federal legislation that impacts CYSHCN program.			X	X
5. Collaborate with Families Together/Family Advisory Council for input and feedback about current and future CYSHCN services.		X	X	X
6. Families and vendors are encouraged to recycle medical equipment to the Kansas Equipment Exchange program to be		X	X	X

refurbished and recycled.				
7. Remind families to keep EPSDT current for additional benefits and support.	X	X	X	
8.				
9.				
10.				

b. Current Activities
Direct Services:

The impact of the expanded newborn screening program and economic downturn in state revenues have been monitored throughout the year. A review of treatment/service eligibility, efficiency and effectiveness, and identification of new and/or additional funding streams is ongoing. We continue to link families with providers who are contracted with or referred by the CYSHCN program and who accept our negotiated rates of reimbursement.

Enabling Services:

The MADIN Web site is updated quarterly to link families with resources and services. Coordination with newborn screening, WIC, tiny k, and injury and disease prevention increases the benefits of early intervention efforts and care coordination, and decreases avoidable injuries and disabilities.

CYSHCN Clinic/Field staff assist families in applying for and maximizing resource benefits and supports.

Population Based Services:

Updates are provided at internal and community meetings to reduce the demand and burden upon families to care for CYSHCN to remain healthy and disability free. Staff monitor listserves, KS-Train, regional and national information to remain current and share relevant information with families.

Infrastructure Building Services:

Increased need and utilization of services/financial supports promotes coordination and collaboration between service providers, linkages, and coalitions. Consumer and provider surveys continue to developed, implemented, evaluated, and shared with families/clinic/field staff.

c. Plan for the Coming Year
Direct Services:

Continue to link families to CYSHCN contracted providers or providers referred by CYSHCN and accept the negotiated reimbursement rates for treatment/services to minimize financial burden/hardship upon families. The impact of newborn screening referrals to CYSHCN and economic downturn in state revenues will be monitored.

Families will continue to utilize EPSDT expanded benefits to decrease out of pocket expenses.

Enabling Services:

CYSHCN and field staff will provide case management to support and assist families in applying for and maximizing funding sources and family supports.

The MADIN Web site will be updated quarterly to link families with resources and services.

Continued coordination with newborn screening, WIC, tiny k, and injury and disease prevention to decrease avoidable injuries and disabilities.

An assessment of primary and specialty care coordination, services, utilization, and gaps to minimize family travel time and missed work/school time will be ongoing.

Population Based Services:

Stakeholder trainings and workshops focusing upon early intervention, prevention of secondary disabilities, injury and disease interventions, cultural competencies, and health equity will be developed and implemented to inform, educate, and reduce the financial and societal burdens upon families of CYSHCN

Infrastructure Building Services:

A needs assessment of primary and specialty care services, utilization, and service delivery gaps to plan, prioritize, and policy development will be done. State services and coverages will be benchmarked with regional states and peer groups.

Continue to monitor, assess, and evaluate state and federal policies and reforms as they relate to health care, coverage, and services.

E. Health Status Indicators

Introduction

Annual tracking on health status indicators contributes to Kansas' ability to: provide information on the State's residents; direct public health efforts; conduct surveillance and monitoring of health issues; and, evaluate the impact of interventions. Data for health status indicators 1-5 are routinely provided to policymakers as, for example, when considering appropriations for prenatal smoking cessation

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.2	7.2	7.1	7.2	7.2
Numerator	2852	2942	2982	3014	3014
Denominator	39701	40896	41951	41815	41815
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008

Data Source: Kansas 2008 Annual Summary of Vital Statistics, Bureau of Public Health Informatics, KDHE

Notes - 2007
Data Source: Kansas 2007 Annual Summary of Vital Statistics, Bureau of Public Health Informatics, KDHE

Narrative:
Reducing births with low birth weight (LBW) is a Kansas MCH priority in the MCH 2010, the 5-Year State MCH Needs Assessment. In Kansas, the percent of LBW increased slightly in 2008, to 7.2% from 7.1% in 2007. For 2008, the most recent year national data (preliminary) is available, the percent of Kansas births with LBW is 12.3% lower than for the U.S (8.2%).

In 2008, no change in total LBW was reported for the non-Hispanic white (6.8%). A small decline was reported for the non-Hispanic black infants (13.1% to 12.9%). However, an incline was reported for the Hispanic infants (5.6% to 6.2%).

In Kansas, LBW is an important issue since 61.4% of all infant deaths occurred among the 7.2% of infants born at LBW. Similarly, 44.4% of infant deaths occurred among the 1.4% of infants born at VLBW.

Recent trends in LBW are influenced by the multiple birth rate. Twins and higher order multiples are much more likely to be born LBW than singletons. In 2007, 55.7% of all plural births in Kansas were LBW.

The risk of LBW was greater for smokers than for nonsmokers (10.3% versus 6.5%), creating an excess LBW risk of 3.8% associated with smoking. Other risk factors for LBW live births include low socioeconomic status, inadequate weight gain during the pregnancy, history of infertility problems, close inter-pregnancy spacing and age of mother.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.5	5.7	5.5	5.7	5.7
Numerator	2117	2271	2244	2302	2302
Denominator	38405	39673	40630	40537	40537
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Birth certificate (resident) data, 2008, Bureau of Public Health Informatics, KDHE

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Bureau of Public Health Informatics, KDHE

Narrative:
This health indicator removes the impact of multiple births on the low birth weight rate. Over the ten year period (1999-2008), there was no significantly increasing or decreasing trend detected. In Kansas for 2008, the percent of singleton LBW births increased 3.6% from 2008. For 2006, the most recent year national birth data (final) is available, the percent of Kansas singleton births with LBW is 11.8% lower than for the U.S.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.3	1.3	1.4	1.4	1.4
Numerator	534	529	573	574	574
Denominator	39701	40896	41951	41815	41815
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Kansas 2008 Annual Summary of Vital Statistics, Table 19, Bureau of Public Health Informatics, Kansas Department of Health and Environment.

Notes - 2007
Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 19, Bureau of Public Health Informatics, Kansas Department of Health and Environment.

Narrative:
Kansas' VLBW rate was 1.4% in 2008, unchanged from 2007. In the last decade (1999-2008), there was no significantly increasing or decreasing trend detected. In 2008, 78.9% of VLBW infants were born at facilities for high-risk deliveries and neonates a 4.7% decrease from 2007 (82.8%). For 2006, the most recent year U.S. birth data (final) is available; the percent of Kansas live births with VLBW is 13.2% lower than the U.S. percent.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Indicator	1.0	1.0	1.0	1.0	1.0
Numerator	376	396	421	420	420
Denominator	38405	39673	40630	40537	40537
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Birth certificate (resident) data, 2008, Bureau of Public Health Informatics, KDHE

Notes - 2007
Data Source: Birth certificate (resident) data, 2007, Bureau of Public Health Informatics, KDHE

Narrative:
This health indicator removes the impact of multiple births on the VLBW percent. In Kansas for 2008, 1.0% of live singleton births were VLBW, unchanged from 2007. The last 5 years (2005 - 2008), there was no increasing or decreasing trend detected. For 2006, the most recent year U.S. birth data (final) is available, the percent of Kansas singleton live births with VLBW is 12.4% lower than for the U.S.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10.3	10.6	9.7	9.3	9.3
Numerator	57	61	56	54	54
Denominator	555339	574097	575333	582572	582572
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Data Source: Kansas 2008 Annual Summary of Vital Statistics, Table 56, Bureau of Public Health Informatics, Kansas Department of Health And Environment.

Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, andY85-Y86) for children (residents) aged 14 years and younger for the reporting period.

Denominator: Number of children (residents) aged 14 years and younger for the reporting period. 2000 US Census (Bridged-Race Vintage series)

Notes - 2007
Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 56, Bureau of Public Health Informatics, Kansas Department of Health And Environment.

Numerator: Number of deaths from all unintentional injuries (ICD-10 Coding, V01-X59, andY85-Y86) for children (residents) aged 14 years and younger for the reporting period.

Denominator: Number of children (residents) aged 14 years and younger for the reporting period. 2000 US Census (Bridged-Race Vintage series)

Narrative:
In 2008, the death rate for children due to unintentional injuries was 9.3 per 100,000, a decrease from 2007 (9.7). Over the nine year period (2000-2008), there was a significant decreasing trend ($p<0.05$) detected in the rate of deaths due to unintentional injuries children aged 14 and younger. Over this same time period, Kansas unintentional injury death rates (ages 0-14) have been consistently higher than for the U.S. (28.6% in 2006, the most recent year with final U.S. death data).

To prevent mortality in this population, the MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry collects information on serious unintentional childhood trauma treated in Kansas hospitals, which will identify risk factors and suggest interventions to be implemented at the regional level.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.9	4.0	3.7	3.6	3.6
Numerator	33	23	21	21	21
Denominator	555339	574097	575333	582572	582572
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for children (residents) aged 14 years and younger for the reporting period. Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 56, Bureau of Public Health Informatics, Kansas Department of Health And Environment.

Denominator: Number of children (residents) aged 14 years and younger for the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series)

Notes - 2007
Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for children (residents) aged 14 years and younger for the reporting period. Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 56, Bureau of Public Health Informatics, Kansas Department of Health And Environment.

Denominator: Number of children (residents) aged 14 years and younger for the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series)

Narrative:
In 2008, the death rate for children due to motor vehicle crashes was 3.6 per 100,000 down 2.7% from 3.7 per 100,000 in 2006. Over the eight year period (2000-2008), there was a decreasing trend detected, however, not statistically significant. For the same time period, Kansas motor vehicle crash death rates (ages 0-14) have been consistently higher than for the U.S. (17.8% higher in 2006, the most recent year with final U.S. death data).

MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry collects information on serious unintentional childhood trauma treated in Kansas hospitals, which will identify risk factors and suggest interventions to be implemented at the regional level.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	31.2	28.9	24.8	26.0	26.0
Numerator	130	120	102	107	107
Denominator	416292	414560	410696	411027	411027
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Fall 2010.

Notes - 2008
Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for youth (residents) aged 15 through 24 years for the reporting period. Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 56, Bureau of Public Health Informatics, Kansas Department of Health And Environment.

Denominator: Number of children (residents) aged 15 through 24 years for the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series)

Notes - 2007
Numerator: Number of deaths from all unintentional injuries due to motor vehicle crashes for youth (residents) aged 15 through 24 years for the reporting period. Data Source: Kansas 2007 Annual Summary of Vital Statistics, Table 56, Bureau of Public Health Informatics, Kansas Department of Health And Environment.

Denominator: Number of children (residents) aged 15 through 24 years for the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series)

Narrative:
In 2008, the death rate for youth in this age group due to motor vehicle crashes was 26 per 100,000 up 4.8% from 2007. Over the eight year period (2000-2008), there was a statistically significant decreasing trend detected. For this time period, Kansas motor vehicle crash death rates (ages 15-24) have been consistently higher than for the U.S. (11.2% higher in 2006, the most recent year with final U.S. death data).

These data led to adoption of SPM 6 and collaborative efforts with SAFE Kids and other groups to address the issue. New legislation in the 2008 session imposes driving restrictions on teens and this will need to be tracked over time.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	270.1	256.2	271.8	242.4	242.4
Numerator	1500	1471	1564	1412	1412
Denominator	555339	574097	575333	582572	582572
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Summer 2010.

Notes - 2008
Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries (E800-E869 and E880-E929). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of resident children ages 14 years and younger in the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series).

Notes - 2007
Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries (E800-E869 and E880-E929). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and

Environmental Statistics, KDHE.

Denominator: Number of resident children ages 14 years and younger in the reporting period. Data Source: 2000 US Census (Bridged-Race Vintage series).

Narrative:
In 2008, the rate of all nonfatal injuries among children ages 14 and younger was 242.4 per 100,000, a 10.8% decrease from 2007 (271.8).

The most common cause of unintentional injury hospitalizations in this age-group is falls followed by poisonings. To prevent morbidity and mortality in this population, the MCH programs are collaborating with SAFE Kids and other community agencies. The Kansas Trauma Registry collects information on serious unintentional childhood trauma treated in Kansas hospitals, which will identify risk factors and suggest interventions to be implemented at the regional level.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	30.4	28.4	27.6	13.4	13.4
Numerator	169	163	159	78	78
Denominator	555339	574097	575333	582572	582572
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available Summer 2010.

Notes - 2008
Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries due to MVC (E810-E825). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Notes - 2007
Numerator: Number of hospital discharges for resident children ages 14 years and younger with non-fatal unintentional injuries due to MVC (E810-E825). Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Narrative:
In 2008, the rate of nonfatal injuries due to motor vehicle crahes among children ages 14 and younger was 13.4 per 100,000, a 51.4% decrease from 2007 (27.6). The rate of nonfatal injuries due to motor vehicle crash was increased 1998-2003 and decreased 2004-2008.

This decrease in hospitalizations caused by MVCs can be attributed to the injury prevention efforts of MCH partners such as SAFE Kids and Kansas Department of Transportation.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	150.4	135.6	140.2	93.7	93.7
Numerator	626	562	576	385	385
Denominator	416292	414560	410696	411027	411027
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
The 2009 column is populated with 2008 data. 2009 data will be available in Summer 2010.

Notes - 2008
Numerator: Number of hospital discharges for youth ages 15 through 24 due to non-fatal injuries caused by motor vehicle crashes (E810-E825) in the reporting period. Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Notes - 2007
Numerator: Number of hospital discharges for youth ages 15 through 24 due to non-fatal injuries caused by motor vehicle crashes (E810-E825) in the reporting period. Data Source: Kansas Hospital Discharge data, Kansas Hospital Association, Accessed throuth th Center for Health and Environmental Statistics, KDHE.

Denominator: Number of youth ages 15 through 24 for the reporting period. Data Source: U. S. Census - Bridged-Race Vintage series.

Narrative:
Injuries from motor vehicle crashes are the leading cause of injury hospitalization among youth in this age group with the highest rate in the 15-19 year old age group. In 2008, the rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years was 93.7 per 100,000, a 33.3% decrease from 2007 (140.2). The rate of nonfatal injuries due to motor vehicle

crash to youth ages 15-24 was increased 1998-2001 and decreased 2001-2008.

This decrease in hospitalizations caused by motor vehicle crashes can be attributed to the injury prevention efforts of MCH grantees and partners such as the Injury and Disability Program section in the Office of Health Promotion and the Kansas Department of Transportation. These groups have worked to increase seat belt usage (see SPM #6) in the 15-19 age group. They advocated for "graduated drivers' licensing" legislation that provides teens with the opportunity to gain more experience under safer conditions before they become fully-licensed drivers.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	25.2	27.2	26.2	28.4	30.9
Numerator	2465	2663	2557	2742	2981
Denominator	97894	97842	97697	96531	96531
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
DATA SOURCE:

Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2009

Denominator= KDHE. Bureau of Public Health Informatics.
KIC - population for the state of Kansas. Because 2009 estimates are not available at the time of this application, 2008data was used to pre-populate this field. Further information and data limitations can be found at http://kic.kdhe.state.ks.us/kic/popeth_table.html

Notes - 2008
DATA SOURCE:

Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2008

Denominator= KDHE. Bureau of Public Health Informatics.
KIC - population for the state of Kansas, CY2008.

Notes - 2007
DATA SOURCE:

Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2007.

Denominator= KDHE. Center for Health and Environmental Statistics

KIC - population for the state of Kansas. Further information and data limitations can be found at http://kic.kdhe.state.ks.us/kic/popeth_table.html

Narrative:
The rates of reported Chlamydia cases continue to increase in Kansas. Female teenagers made up 34% of all cases reported to the state. Yet teenage males only make up 13% of all case reports for teenagers 15-19 years old. Large disparities in rate persist for minorities, particularly African Americans. According to Kansas Youth Risk Behavior Survey (YRBS), 45% of teens reported ever having sexual intercourse and 15.4% of those who had intercourse had at sex with at least three partners in their lifetime. Of those sexual active teens in Kansas, only 65.8% reported using a condome during last sexual intercourse. Due to budgetary problems and STD program realignment, interventions aimed specifically at Chlamydia stopped beginning in 2009.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.0	8.3	8.9	9.9	11.2
Numerator	3745	3825	4067	4508	5126
Denominator	468937	460954	458243	456950	456950
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
DATA SOURCE:

Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2009

Denominator= KDHE. Bureau of Public Health Informatics.
KIC - population for the state of Kansas. Because 2009 estimates are not available at the time of this application, 2008 data was used to pre-populate this field. Further information and data limitations can be found at http://kic.kdhe.state.ks.us/kic/popeth_table.html

Notes - 2008
DATA SOURCE:

Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2008

Denominator= KDHE. Bureau of Public Health Informatics.
KIC - population for the state of Kansas, CY2008.

Notes - 2007
DATA SOURCE:
Numerator= KDHE. Bureau of Disease Prevention and Control. STD program data on incident cases reported for CY2008

Denominator=KDHE. Center for Health and Environmental Statistics
KIC - population for the state of Kansas. Further information and data limitations can be found at http://kic.kdhe.state.ks.us/kic/popeth_table.html

Narrative:
The rates of reported Chlamydia cases continue to increase in Kansas. Female reproductive women comprise 41% of all cases reported to the state. Yet adult males only make up 26% of all case reports for individuals aged 20-44. Some of the highest rates are reported for the largest metropolitan counties in Kansas, where increasingly more of the population reside. The most monthly reported cases of Chlamydia occur in August, followed by the months of July and February. Large disparities in rate persist for minorities, particularly African Americans. Due to budgetary problems and STD program realignment, interventions aimed specifically at Chlamydia stopped beginning in 2009.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	42091	35985	4147	632	1327	0	0	0
Children 1 through 4	118013	101540	11074	2007	3392	0	0	0
Children 5 through 9	192365	166607	17665	2820	5273	0	0	0
Children 10 through 14	187678	164238	16390	2536	4514	0	0	0
Children 15 through 19	199858	175577	17233	2934	4114	0	0	0
Children 20 through 24	170024	149816	13711	2511	3986	0	0	0
Children 0 through 24	910029	793763	80220	13440	22606	0	0	0

Notes - 2011
DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from:
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from:
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from:
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from:
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from:
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from:
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

Narrative:
Although Kansas had slightly more births (infants) and young school age children (5-9) than 2007, the state overall seen a decline in children--about 39,000 less children under the age of 20. The losses were largest in white and African-American children in Kansas. The economic downturn may have caused these groups to look for better job opportunities in larger metropolitan areas or fall back on family members residing outside of Kansas. In 2008, racial demographics of Kansas children were 87.2% white, 8.8% African-American, 1.5% Native American, and 2.5% Asian or Pacific Islander.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	34869	7222	0
Children 1 through 4	98685	19328	0
Children 5 through 9	163741	28624	0
Children 10 through 14	163223	24455	0

Children 15 through 19	178837	21021	0
Children 20 through 24	154025	15999	0
Children 0 through 24	793380	116649	0

Notes - 2011

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009

Note-- Asian and Pacific Islander racial categories have been combined.

Narrative:

Although growth was slower this year than last, Kansas continues to see an increase in the number of Hispanic Children. Although the economic downturn may have caused young adults (20-24) to move out of the state, Hispanics children under 20 years of age comprise 13.6% of the population. Increasingly programs are distributing and translating health messages in spanish as well as hiring bilingual staff to serve this growing population subgroup.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	40	20	10	0	1	0	3	6
Women 15 through 17	1261	860	178	6	9	4	39	165
Women 18 through 19	3138	2348	374	37	37	2	88	252
Women 20 through 34	33002	27169	2243	226	881	52	492	1939
Women 35 or older	4370	3626	190	21	238	4	43	248
Women of all ages	41811	34023	2995	290	1166	62	665	2610

Notes - 2011

Narrative:
Live birth data by maternal age and race is readily available through Kansa's Vital Statistics. Kansas started using the revised birth certificate in 2005 which allowed for expanded race categories including native Hawaiian or other Pacific Islander and multi race.

For 2008 data, 98.4% of births were to women who only selected one race, while 1.6% selected two or more races. White race alone was selected for 81.4% of live births, black race was 7.2% of live births, Asian 2.8% of live births, Native American 0.7% of live births, native Hawaiian or other Pacific Islander 0.1%, and race was unknown 0.2% of live births.

In 2007, women of Hispanic ethnicity accounted for 16.2% of live births, a slight increase from 2007 (15.9%). With the revised birth certificate, race data was collected in a different manner for Hispanic mothers. Before 2005, mothers of Hispanic origin were assigned white race unless they indicated another race. In the years 2002-2004, almost 1% (0.9%) of Hispanic mothers selected "other" race. In 2008, about 1 out of 3 (34.8%) selected "other race" as their race. Thus, the counts for white births through 2004 are not compatible with births by race from 2005 forward. With less Hispanics included in the white race data, certain percents or rates among white females may be affected such as teen pregnancy rates and smoking during pregnancy.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	29	11	0
Women 15 through 17	847	411	3
Women 18 through 19	2445	688	5
Women 20 through 34	27946	5000	56
Women 35 or older	3689	671	10
Women of all ages	34956	6781	74

Notes - 2011

Narrative:
Live birth data by maternal age and race is readily available through Kansa's Vital Statistics. Kansas started using the revised birth certificate in 2005 which allowed for expanded race categories including native Hawaiian or other Pacific Islander and multi race.

For 2008 data, 98.4% of births were to women who only selected one race, while 1.6% selected two or more races. White race alone was selected for 81.4% of live births, black race was 7.2% of live births, Asian 2.8% of live births, Native American 0.7% of live births, native Hawaiian or other Pacific Islander 0.1%, and race was unknown 0.2% of live births.

In 2007, women of Hispanic ethnicity accounted for 16.2% of live births, a slight increase from 2007 (15.9%). With the revised birth certificate, race data was collected in a different manner for Hispanic mothers. Before 2005, mothers of Hispanic origin were assigned white race unless they indicated another race. In the years 2002-2004, almost 1% (0.9%) of Hispanic mothers selected "other" race. In 2008, about 1 out of 3 (34.8%) selected "other race" as their race. Thus, the counts for white births through 2004 are not compatible with births by race from 2005 forward. With less Hispanics included in the white race data, certain percents or rates among white females may be affected such as teen pregnancy rates and smoking during pregnancy.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	303	212	41	4	5	0	15	26
Children 1 through 4	64	47	7	1	2	0	0	7
Children 5 through 9	16	9	3	0	2	0	1	1
Children 10 through 14	35	28	5	1	0	0	0	1

Children 15 through 19	124	95	14	2	2	0	4	7
Children 20 through 24	225	164	35	3	2	1	5	15
Children 0 through 24	767	555	105	11	13	1	25	57

Notes - 2011

Narrative:
The death certificate data for children by age group by race (HSI #08A) is readily available from Vital Statistics as is death certificate data for children by age group by ethnicity (HSI #08B). These tables are useful as a tool in public health planning and implementation efforts, as for instance when estimating the school age population for a particular intervention or when there is a need to pull together data quickly for a meeting.

In 2008, there were 767 deaths to childen ages 0-24 with 303 of deaths to infants. Based on the proportion of black or African-American children in the Kansas population, black children have proportionately greater numbers of deaths than other races. Black children comprise 8.8% of the States' children but 13.7% of the deaths to children. Black infants comprise 9.9% of the States' infants but 13.5% of the deaths to infants. Hispanic children comprise 12.8% of the States' children but 15.4% of the deaths to children. Hispanic infants comprise 15.1% of the States' infants and 18.8% of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	242	57	4
Children 1 through 4	54	10	0
Children 5 through 9	12	4	0
Children 10 through 14	30	5	0
Children 15 through 19	106	16	2
Children 20 through 24	198	26	1
Children 0 through 24	642	118	7

Notes - 2011

Narrative:
The death certificate data for children by age group by race (HSI #08A) is readily available from Vital Statistics as is death certificate data for children by age group by ethnicity (HSI #08B). These tables are useful as a tool in public health planning and implementation efforts, as for instance when estimating the school age population for a particular intervention or when there is a need to pull together data quickly for a meeting.

In 2008, there were 767 deaths to childen ages 0-24 with 303 of deaths to infants. Based on the proportion of black or African-American children in the Kansas population, black children have proportionately greater numbers of deaths than other races. Black children comprise 8.8% of the States' children but 13.7% of the deaths to children. Black infants comprise 9.9% of the States' infants but 13.5% of the deaths to infants. Hispanic children comprise 12.8% of the States' children but 15.4% of the deaths to children. Hispanic infants comprise 15.1% of the States' infants and 18.8% of the deaths to infants. These latter data suggest that there may be a slightly greater risk for Hispanic children as they age.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	740005	643947	66509	10929	18620	0	0	0	2008
Percent in household headed by single parent	29.1	26.3	55.3	57.6	26.9	0.0	30.4	0.0	2009
Percent in TANF (Grant) families	6.1	4.9	16.9	7.4	4.4	0.0	0.0	0.0	2009
Number enrolled in Medicaid	227524	168057	36626	4309	4153	305	0	14074	2009
Number enrolled in SCHIP	61365	48803	5984	799	1357	66	0	4356	2009
Number living in foster home care	8362	6494	1685	90	38	11	0	44	2009
Number enrolled in food stamp program	167376	119507	29882	2701	2599	240	4330	8117	2009
Number enrolled in WIC	96562	76254	11111	2548	1525	242	4882	0	2009
Rate (per 100,000) of juvenile crime arrests	2822.2	2591.5	5777.2	1628.5	1035.9	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	2.4	1.4	2.4	3.1	1.0	0.0	1.5	0.0	2008

Notes - 2011

DATA SOURCE: National Center for Health Statistics. Estimates of the July 1, 2000-July 1, 2008, United States resident population from the Vintage 2008 postcensal series by year, county, age, sex, race, and Hispanic origin, prepared under a collaborative arrangement with the U.S. Census Burau. Available on the Internet from:
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm. September 8, 2009.

Note-- Asian and Pacific Islander racial categories have been combined.

DATASOURCE:
U.S. Census Bureau. 2009 Current Population Survey (CPS), Annual Social and Economic Supplement. Custom table all persons by race and kind of family for KS children 0-17 years old.

Note*
Native Hawaiian or Other pacific Islander were to small to estimate

DATA SOURCE: Kansas Department of Social and Rehabilitation Services (SRS). Unduplicated TANF (CASH) recipients in KS AGE 0 to 19 during calendar year 2009 based on self-reporting of race/ethnicity to SRS.

Note—Asian and Pacific Islander racial categories have been combined together.

DATA SOURCE: Kansas Health Policy Authority. - Title 19 race and ethnicity report, ages 19 and under, CY 2009.

DATA SOURCE: Kansas Health Policy Authority. - Title 21 race and ethnicity report, ages 19 and under, CY 2009.

DATA SOURCE: Kansas Department of Social and Rehabilitation Services (SRS). Unduplicated food assistance recipients in KS AGE 0 to 19 during calendar year 2009 based on self-reporting of race/ethnicity to SRS.

DATA SOURCE: KDHE. Bureau of Family Health. WIC program data. Calendar Year 2009 – KWIC Racial Statistics for clients 19 years of age and younger.

DATA SOURCE:
Kansas Bureau of Investigation. Total arrests made youths aged 5-19, CY 2009.

Note: Asian and Pacific Islander racial categories have been combined. This data should not be used to make comparisons to previous years. Due to staff and budget constraints, not all arrest data was entered into KBI's system by this deadline. While it is believed that
Juvenile arrests declined in 2009 this data does not represent a complete picture.

DATA SOURCE:
Numerator=Kansas State Department of Education. KANSAS
UNIFIED SCHOOL DISTRICT DROPOUTS: 2004-2008 Five Year Dropout History.

Denominator=Kansas State Department of Education. KANSAS
STATE REPORTS. Enrollments by age, gender, race, and ethnicity 2008 -2009 Headcounts.

Note: Due to administrative changes to comply with FERPA regulations, racial/ethnic estimates are not comparable with previous years' submissions. Racial and ethnic breakdown of school dropouts for 2008 school year includes grades 7 through 12.

DATA SOURCE:
Kansas Department of Social and Rehabilitation Services (SRS Children and Family Services), children in out of home placement, State Fiscal Year 2009.

Narrative:
The economic downturn has hit families particularly hard in Kansas. Nearly all state assistance programs have seen an increase in the number of children served from last reporting year--3% for TANF, 6% for Medicaid, 2% for Healthwave/SCHIP, 18% for food stamps, and 5% for WIC. However, the number of children in foster care has declined by 9% from last reporting year. This decline in foster stemmed from budgetary reductions that impacted both investigations/referrals and foster home vacancies. The soured economy has also led to a 5% decline in child population as more parents move out of the state for better employment or childcare opportunities. This is evident by the large reductions in white and African-American child populations in Kansas.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	639355	100650	0	2008
Percent in household headed by single parent	29.1	32.4	0.0	2009
Percent in TANF (Grant) families	6.1	9.2	0.0	2009
Number enrolled in Medicaid	173033	54491	0	2009
Number enrolled in SCHIP	45383	15980	0	2009
Number living in foster home care	7447	915	0	2009
Number enrolled in food stamp program	124992	34267	8117	2009
Number enrolled in WIC	64597	31888	77	2009
Rate (per 100,000) of juvenile crime arrests	2658.2	3572.2	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	1.5	2.5	0.0	2008

Notes - 2011
DATASOURCE:
U.S. Census Bureau. 2009 Current Population Survey (CPS), Annual Social and Economic Supplement. Custom table all persons by hispanic origion and kind of family for KS children 0-17 years old.

Note*
Native Hawaiian or Other pacific Islander were to small to estimate

Narrative:
The Hispanic community continues to grow in Kansas. Unlike the different racial populations, the Hispanic population has been relatively stable since last reporting year. About one in seven children in Kansas are Hispanic. Similar to the rest of the state, state assistance programs report

an increase enrollments for both Hispanic and non-Hispanic children.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	458759
Living in urban areas	542058
Living in rural areas	176869
Living in frontier areas	21078
Total - all children 0 through 19	740005

Notes - 2011
DATA SOURCE:
U. S. Census Bureau. Bridged Race Population, 2008.
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm

Kansas Vital records definition of Metropolitan Counties was used in this analysis. These counties are: Butler, Douglas, Harvey, Johnson, Leavenworth, Miami, Sedgwick, Shawnee, and Wyandotte.

DATA SOURCE:
U. S. Census Bureau. Bridged Race Population, 2008.
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm

Kansas Vital records definition of urban and semi-urban counties were used in this analysis. Counties were included if they had population densities of 40 or more persons per square mile. These counties are: Douglas, Johnson, Sedgwick, Shawnee, Wyandotte, Butler, Crawford, Franklin, Geary, Harvey, Leavenworth, Lyon, Miami, Montgomery, Reno, Riley, and Saline.

DATA SOURCE:
U. S. Census Bureau. Bridged Race Population, 2008.
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm

Kansas Vital records definition of rural and densely-settled rural counties were used in this analysis. Counties included had population densities between 6 and 39 persons per square mile. These counties are: Allen, Atchison, Barton, Bourbon, Cherokee, Cowley, Dickinson, Doniphan, Ellis, Finney, Ford, Jefferson, Labette, McPherson, Neosho, Osage, Pottawatomie, Seward, Sumner, Anderson, Brown, Chautauqua, Clay, Cloud, Coffey, Ellsworth, Grant, Gray, Greenwood, Harper, Haskell, Jackson, Kingman, Linn, Marion, Marshall, Mitchell, Morris, Nemaha, Norton, Ottawa, Pawnee, Philips, Pratt, Republic, Rice, Rooks, Russell, Sherman, Thomas, Wobaunesse, Washington, Wilson, And Woodson.

DATA SOURCE:
U. S. Census Bureau. Bridged Race Population, 2008.
http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm

Kansas Vital records definition of frontier counties was used in this analysis. Counties included had population densities that had fewer than 6 persons per square mile. These counties are: Barber, Chase, Cheyenne, Clark, Comanche, Decatur, Edwards, Elk, Gove, Graham, Greeley, Hamilton, Hodgeman, Jewell, Kearny, Kiowa, Lane, Lincoln, Logan, Meade, Morton, Ness, Osborne, Rawlins, Rush, Sheridan, Smith, Stanton, Stafford, Scott, Trego, Wallace, and Wichita.

Narrative:
Kansas continues to follow national and internation trends of the population becoming increasingly concentrated in urban areas. In 2008, 73% of children lived in urban counties (greater than 40 persons per square mile), 24% in rural counties (population between 6-40 persons per square mile), and 3% in frontier counties (less than 6 persons per square mile). Although urban counties continue to increase at the expense of rural and frontier counties, this rate of growth in urban counties accelarated beginning in 2005. Serving children and families in rural and frontier areas of the state remains a challenge.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2802134.0
Percent Below: 50% of poverty	4.8
100% of poverty	12.7
200% of poverty	31.5

Notes - 2011
DATA SOURCE:
U.S. Census Bureau and Bureau of Labor Statistics. State and County QuickFacts: Kansas, 2008. Further information can be found at http://quickfacts.census.gov/qfd/states/20000.html

DATA SOURCE:
U.S. Census Bureau. 2006-2008 American Community Survey 3-Year Estimates S1703. Selected Characteristics of People at Specified Levels of Poverty in the Past 12 Months. Further information can be found at http://www.census.gov/acs/www/.

This column is not comparable with applications prior to 2008

DATA SOURCE:
U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2009 Below 100% and 125% of Poverty -- All Ages. Further information can be found at http://www.census.gov/hhes/www/cpstables/032009/pov/new46_100125_01.htm

DATA SOURCE:
U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2009 Below 200% and 185% of Poverty -- All Ages. Further information can be found at http://www.census.gov/hhes/www/cpstables/032009/pov/new46_185200_01.htm

Narrative:
Due to widespread economic crisis, more of the population in Kansas has fallen in poverty. Individuals living at 100% or 200% of federal poverty level increased by about 1 percentage point since 2007. This may partially explain the large increases seen in Medicaid and other government assistance programs.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	700534.0
Percent Below: 50% of poverty	5.9
100% of poverty	17.1
200% of poverty	41.1

Notes - 2011
DATA SOURCE:
U.S. Census Bureau and Bureau of Labor Statistics. State and County QuickFacts: Kansas, 2008. Further information can be found at http://quickfacts.census.gov/qfd/states/20000.html

DATA SOURCE:
U.S. Census Bureau. 2006-2008 American Community Survey 3-Year Estimates S1703. Selected Characteristics of People at Specified Levels of Poverty in the Past 12 Months. Further information can be found at http://www.census.gov/acs/www/.

This column is not comparable with applications prior to 2008

DATA SOURCE:
U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2009 Below 100% and 125% of Poverty -- People Under 18 Years of Age. Further information can be found at http://www.census.gov/hhes/www/cpstables/032009/pov/new46_185200_03.htm

DATA SOURCE:
U.S. Census Bureau and Bureau of Labor Statistics. Current Population Survey (CPS). Annual Social and Economic (ASEC) Supplement. POV46: Poverty Status by State: 2009 Below 200% and 185% of Poverty -- People Under 18 Years of Age. Further information can be found at http://www.census.gov/hhes/www/cpstables/032009/pov/new46_185200_03.htm

Narrative:
The economic crisis has hit children particullarly hard. A significantly greater percentage of children are in poverty at all levels in Kansas than in comparison with adults. About 2 in 5 kansas children live below 200% of Federal Poverty level. This is a percentage point higher than it was in 2007.

F. Other Program Activities

State MCH program activities have considerable breadth. Many fall outside the parameters of priority needs and National and State performance measures. Some make significant contributions to the health and well-being of mothers and infants, children, and CYSHCN.

Integrated Services

In June 2009 the CYSHCN Program, in partnership with the University of Kansas Center on Developmental Disabilities, was awarded a HRSA D-70 Integrated Community Systems for Youth with Special Health Care Needs grant to ensure that Kansas youth with special health care needs

and their families receive culturally competent, uninterrupted, age-appropriate services that meet their needs and promotes healthy, productive and independent adult lives. Grant objectives include strengthening patient-family-professional partnerships, enhancing access and services received within a medical home, addressing transition to adulthood, and building system capacity and sustainability.

Grant activities include information-sharing and collaboration with partners across the state of Kansas; development and implementation of a transition planning curriculum, utilizing technology-oriented strategies; training for consumers and professionals; development of resource guides and navigational tools; coordination of transition planning meetings; support youth with special health care needs to be empowered and independent; provide funding for the development or expansion of activities supportive of the grant objectives and much more. This grant provides the opportunity to enhance the health, education and workforce development possibilities for youth and young adults with disabilities.

Special Efforts made to address Health Disparities

MCH engaged in an assessment of its programs with the new Director of the Office of Minority Health, now the Bureau of Minority Health. The purpose of the assessment was to determine areas of possible collaboration. The new Director of the Bureau has a strong background in prevention/wellness, social determinants of health, lifecourse perspective and health equity. She has served at the local level in health promotion activities in the Wichita areas. Her first order of business is to develop a financial base for her bureau through federal funding. She has a unique perspective with strong contacts in the tribal community.

Multi-State Learning Collaborative-3 (MLC-3)

In early 2008, sixteen states including Kansas were selected through a competitive process to lead a national initiative to advance accreditation and quality improvement efforts in public health departments. Sponsored by the Robert Wood Johnson Foundation and administered by the Network of Public Health Institutes, a series of projects were initiated improve public health. MCH played a lead role in MLC-3 to improve access to prenatal care through a regional approach. State and local teams test and measure practice innovations, then share their experiences in an effort to accelerate learning and widespread implementation of best practices. http://www.kalhd.org/MLC3MCH/

Woman's Right to Know (WRTK) Materials and Video

During the 2009 session there were major amendments to the WRTK law. These required the department to revise certification of informed consent forms, handbooks showing fetuses at 2 week intervals, directory of services for pregnant women by county including locations of free sonograms all n English and Spanish. The law added a new requirement this year: videos in English and Spanish that contain all the material in the handbooks. These were developed over a 3-month period by MCH staff in collaboration with Local and Rural Health staff all within existing resources. All the materials are available on-line at http://www.kansaswomansrighttoknow.org/

State Early Childhood Comprehensive Systems and LAUNCH

Kansas MCH administers the ECCS grant with project management provided by KU's Institute for Educational Research and Public Service and coordination through the Kansas Children's Cabinet. The project serves as the focal point for early childhood collaborative efforts in the state. These include advocacy, planning, professional development, and other. KU's Institute also provides project management for the five-year LAUNCH grant from SAMHSA. This federal grant supports one pilot community (Garden City) in the state to build a collaborative system among all early childhood providers. It also supports a comprehensive program evaluation effort through the KU Institute.

Other Program Activities

This year Kansas WIC rolled out a new on-line system for the state. The KWIC system creates efficiencies that relieve local health department staff from mundane paperwork tasks so that they can spend more time with clients during clinic sessions. This year MCH negotiated a new contact with the Interagency Coordinating Council, the group that provides advice and assistance to the lead agency (KDHE) for Part C of IDEA. This year's contract builds in new accountability for work performed including orientation and training of new board members, transparency in process of recruiting new board members, annual report to the legislators, and technical assistance to local ICCs. The draft form of the new birthing center regulations is in the last stages of approval in the rules and regulations process. The new regulations will be in line with national standards. MCH participated in review and recommendations for the new regulations.

Discussion of the Toll-Free Hotline

The Make A Difference Information Network (MADIN) is a collaborative effort among the Kansas Department of Health and Environment, the Kansas State Department of Education, the Kansas Department of Social and Rehabilitation Services, and Oral Health Kansas. Its purpose is to connect Kansans and service providers with resources and services for individuals with disabilities. MADIN promotes individual responsibility by providing links to topics of interest. Information and resources are available in English and Spanish and directly linked to the MADIN web site (www.makeadifferenceks.org). The MADIN toll free line 1- 800-332-6262 (in Kansas only) is staffed 8 - 5 Monday through Friday. MADIN is a navigational tool for both consumers and providers.

Medicaid Reimbursement Cuts

The KHPA reached an agreement with a group of durable medical equipment suppliers after an approximate 2 month service disruption. The agreement will allow Medicaid beneficiaries who need wheelchairs to continue receiving the equipment that is vital to their health, mobility, and independence.
An attachment is included in this section.

G. Technical Assistance

Infant Mortality Reduction

This past year, Kansas requested and received technical assistance on infant mortality reduction with an emphasis on black infant mortality. Rosemary Fournier from Michigan FIMR presented to the Kansas Blue Ribbon Panel on Infant Mortality, a subcommittee of the Governor's Child Health Advisory Committee. She provided an overview of how data from PRAMS and FIMR have guided Michigan with good examples from Detroit. Then she facilitated a discussion with panelists about next steps. The panel adopted a number of recommendations which are posted on this website -- http://www.datacounts.net/infant_mortality/

During the 2010 session, they focused on changing the Vital statutes that have prohibited use of birth certificates for "follow-back" that is, for PRAMS and FIMR. The result is this law http://www.kslegislature.org/bills/2010/2454.pdf Hooray for our Panel members (especially Kansas Action for Children and March of Dimes). They worked hard to get this bill through the legislature. And there were many ups and downs. We are very grateful to them and for the technical assistance that helped moved this process along.

Birth Defects Information System

For the coming year, Kansas is requesting technical assistance from CDC. Senate Bill 418

passed in the 2004 Kansas legislative session. It creates, pending the availability of funding, a birth defects surveillance system. The statutory language is similar to that of model statutes for the State of Ohio. BCYF submitted an application to the CDC for funding of a birth defects surveillance system. The application was approved but not funded. Resources are not available to establish a surveillance system at this time. Some very limited components of a system such as a database are maintained using MCH federal funds. BFH needs CDC technical assistance to review current efforts and to make recommendations about next steps.

Funding Formulas and Financing Mechanisms for MCH programs

Also for the coming year, Kansas is requesting technical assistance on funding formulas and financing mechanisms for MCH programs. After many years of level funding (both state and local MCH funds), and some recent reductions, there is a need to reevaluate the current funding strategies. Technical assistance from MCH directors in other states and from the federal offices would be useful.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4700774	4718608	4719246		4718608	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	4659442	4512530	4079395		4462639	
4. Local MCH Funds *(Line4, Form 2)*	4261972	4782085	5475000		4374000	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	13622188	14013223	14273641		13555247	
8. Other Federal Funds *(Line10, Form 2)*	62362445	72448016	70812887		72444016	
9. Total *(Line11, Form 2)*	75984633	86461239	85086528		85999263	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	2559173	2788564	2800492		2774634	
b. Infants < 1 year old	2559174	2788564	2800492		2774635	
c. Children 1 to 22 years old	5423785	6132606	5868371		5456728	
d. Children with	2594476	1937112	2415786		2179250	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	485580	366377	388500		370000	
g. SUBTOTAL	13622188	14013223	14273641		13555247	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		94644	
c. CISS	140000		140000		132000	
d. Abstinence Education	337112		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	54889700		61543000		62000000	
h. AIDS	0		0		0	
i. CDC	100000		100000		100000	
j. Education	3887531		5851667		4030759	
k. Other						
Family Planning	2379479		2482320		2300000	
Other	0		0		3786613	
NBHS, BF, XIX, SRS	0		601256		0	
NBHS, BF, XIX, SRS	533979		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	5304203	4666526	4877888		1086334	
II. Enabling Services	6101176	6951535	7570830		6901877	
III. Population-Based Services	1115094	1227408	566913		4254786	
IV. Infrastructure Building Services	1101715	1167754	1258010		1312250	
V. Federal-State Title V Block Grant Partnership Total	13622188	14013223	14273641		13555247	

A. Expenditures

Expenditures Narrative FFY 09 "A"

Form 3 - FFY 09 Block Grant partnership expenditures were as follows: $4,718,608 federal; $4,512,530 state; and $4,782,085 local. In comparison, for FFY 08, Block Grant partnership expenditures were: $4,700,774 federal; $4,706,827 state; and $5,928,079 local match. Comparing FFY 08 and FFY 09 there were increases in all expenditures categories.

In FFY 09, MCH spent federal dollars within the amount available and also compatible with the priority needs identified in the State Needs Assessment.

In FFY 09, federal MCH funding to support MCH initiatives was expended within the department as follows: Office of Health Assessment $23,824; Office of Local and Rural Health $41,508; Child Care Licensing and Registration $171,780; Office of Oral Health $16,677. Within the Bureau of Family Health (the MCH unit within KDHE) $416,095 in federal MCH funds was spent for staff and operating costs working in programs for Pregnant Women & Infants, and for Children & Adolescents. Staff, operating costs, and CYSHCN contracts and supplies were $1,109,194. Nutrition consultation through the WIC program was $1,801. Aid to Local agencies and contracts with providers for MCH services totaled $2,278,115.
Newborn screening follow-up expenditures (2 salaries) were $106,475. Salary and operating for one epidemiologist was $86,762. Expenditures for the director and assistant were just under $100,000 while indirect costs totaled $366,377.

Federal MCH dollars have declined over the past 17 years from $5,004,067 in FFY 94 to $4,718,608 in FFY 10. While the amount of this decline is only around $300,000, taking into account inflation, the Kansas federal MCH grant has lost over a third of its spending value. What cost $5 million in FFY 94, would cost $7.4 million today. To a great extent increased costs have shifted to state and local governments. MCH dollars have been directed towards priority work with accountability for work performed.
For FY 09, State dollars in the amount of $284,685 were expended for Pregnancy Maintenance Initiative. This funding accounts for much of the variability from year to year in state expenditures. It is routinely cut by executive branch and then some or all is restored by legislative branch.

Local agency expenditures data is obtained from the quarterly expenditure affidavits submitted by local agencies. All MCH local agencies meet contractual matching requirements of 40%, however, most provide a 100% plus match. A very few local health departments have had difficulties meeting minimal local matching requirements. We continue to monitor this situation as local budgets tighten.

Form 4 - Two other items relating to expenditures should be noted here: 1) When considering federal MCH funds only, the state meets its federal obligation of 30-30 that is, equity in funding for each of the three population groups. When considering all Block Grant partnership expenditures, the Children and Adolescent (C&A) services funding is three times the funding for CYSHCN, and 2.5 times that for Pregnant Women & Infants (P&I). The reason for this is twofold. First, CYSHCN contracts require no local matching dollars. Second, MCH grants to local communities do not require services to CYSHCN. Various solutions to address this have been proposed such as requiring CYSHCN contractors to provide a match, or require that local MCH agencies serve children with special health care needs, and/or a combination of these. Such changes are not likely to take place in the near future.

Another item worth noting is that the funding paradigm has shifted in the MCH grants to local agencies. Previously, services were weighted towards pregnant women and infants through such programs as M&I and Healthy Start Home Visitor. After consolidation of these two grants with the Child Health grants to make one MCH grant, the instruction to local agencies was to allocate resources 50% to pregnant women and infants, and 50% to children and adolescents. Since there were already other aid to local grants focusing on youth services (e.g., teen pregnancy, disparity, school health) the effect of this change was a slight over-allocation of resources to the C&A population group.

Form 5 - Direct health care expenditures are approximately 8% of the total MCH budget. Enabling services are 51% of the overall budget with population-based at 31% and core public health at 10% each. Over the past five years of this program, there has been a shift away from expenditures for direct services towards other levels of the pyramid.

With State expenditures of $4,512,530 in FFY 09, the State of Kansas is well within its required

maintenance of effort requirement of $2,352,511.

Kansas meets its 75% matching requirement through use of State funds (96% match). When considering both State and local matching funds, Kansas provides a 197% match. The increase in state and local fiscal responsibility for the program has continued over the past five years.

Detailed information about the Federal-State Title V Block Grant Partnership is provided on the attached Excel spreadsheet.

An attachment is included in this section.

B. Budget

Budget Narrative FFY 11

Form 2 - For FFY 11, the Block Grant partnership budget for MCH federal dollars is $4,718,608. This is the full amount of the anticipated federal Title V award. There is an additional $70 million other federal dollars and $6.4 million other state dollars budgeted.

For FFY 11, the Block Grant partnership budget is: $4,718,608 federal; $4,462,639 state; and $4,374,000 local match. In very rough terms, overall Kansas Maternal and Child Health Services' funding is one-third federal, one-third state, and one-third local funding. In other words, Kansas provides nearly a 100% match for the federal dollars. Local agencies also provide an additional 100% match.

Comparing the budgeted amounts of MCH dollars for FFY 10 and FFY 11 there is little difference except for the reduction in funds for Office of Oral Health ($75,000) and redirecting some MCH Aid to Local grant funding from direct services to other levels of the pyramid.

Form 2 - Amounts of funding allocated to children and adolescents and CYSHCN are very similar. Kansas meets its 30-30 allocation requirement with $1,521,434 (32%) of the federal grant allocated to children and adolescents and $1,511,836 (32%) allocated to children with special health care needs.

Form 3 - Kansas' budget for FFY 11 meets its maintenance of effort requirement of $2,352,511. The Title V matching requirement of 75% is achieved through projected State matching funds of $4,462,639 (95%). Kansas also anticipates receiving $4,374,000 in local match.

Form 4 - Of its overall MCH budget (fed, state/local match), Kansas allocates about $2.7 million to services for pregnant women and $2.7 for infants. Another $5.4 million is allocated to children and adolescents and $2.2 million for CYSHCN.

Form 5 - Considering the overall MCH budget, about $1 million (8%) is allocated to direct services, $6.9 million (50%) to enabling services such as case management and transportation. $4.2 million and $1.3 million are allocated respectively to population-based services and to core public health infrastructure services.

On July 1, 2007, the indirect cost rate for the Kansas MCH program went 14.4% to 20.1%. It went up another percentage point on July 1, 2008. Costs for administration of the program (for Kansas MCH this has been defined as MCH administration and indirect costs, now only indirect costs) are within the 10% limit set forth in federal Title V law. At this time, Kansas is in compliance with all requirements of the law.

Detailed information about the FFY 11 budget is provided in the attached Excel spreadsheet.

The State of Kansas assures that the MCH and CYSHCN Directors provide input into the

allocation and budgeting process for the MCH Block Grant, into the state budget, and into the process of prioritizing programs for MCH resources based on the State MCH needs assessment.

CYSHCN contracts -- This Section administers grant funding for medical specialty clinics and a statewide system of services for children and their families. Contracts for this section include:
Advanced Orthopedics - $10,800
Cerebral Palsy Research - $156,400
Center for Child Health & Development at KU - $169,340
Center for Child Health and Development, KU, Kansas City Office - $145,068
Department of Pediatrics at KU Medical Center - $159,259
Families Together, Inc. - $45,000
Spesticity & Mobility Clinic - $5,400
Wichita Medical Practice - $95,000
Via Christie Medical Center in Wichita - $22,500
Wesley Clinics, Wichita - $43,959
UKSM, Wichita Office $261,012

In addition, Wichita Medical Research and Educational Foundation is reimbursed $14 per sickle cell lab test. The Kansas State Department of Education and the Kansas Department of Social and Rehabilitation Services provide federal funding of $34,730 total to support the toll-free number -- Make a Difference Information Network. The State Department of Education provides $7,000 for Special Child Clinics (rural outreach clinics (e.g., Oakley). In SFY 08, CYSHCN received $208,000 new funds from Tobacco Settlement funds to help offset costs related to PKU formula. In SFY 09, CYSHCN is receiving an additional $200,000 in Tobacco Settlement funds to help with diagnostic and treatment costs associated with expansion of newborn screening. So the total funding for CYSHCN from Tobacco Settlement funds (called Children's Initiative Funds in Kansas) is now at $408,000.

The Children & Families Section administers MCH grant funding for local agencies relating to: perinatal and reproductive health services, and child and adolescent health services. The contracts for this section include: MCH-- 85 contracts with local health departments and other local agencies for coverage of all 105 counties; Family Planning -- 58 contracts with local health departments and 3 other local agencies for coverage of all counties. In addition there are teen pregnancy prevention projects (see below). There are 12 contracts for school nurse/public health nurse collaborative practice. SIDS Network of Kansas - $75,000

For more detail about the breakdown of the Federal State Title V Block Grant partnership, please see the attachment to this section.

Following is the list of MCH contracts with local agencies for SFY 11 -- totaling $4,085,776
Barber Co Health Dept $4,413
Barton Co Health Dept (multi county) $61,248
Butler Co Health Dept $51,244
Chase Co Health Dept $2,798
Chautauqua Co Health Dept $8,160
Cherokee Co Health Dept $30,176
Cheyenne Co Health Dept $3,083
Clay Co Health Dept $38,422
Cloud Co Health Dept $9,145
Coffey Co Health Dept $5,887
Cowley Co Health Dept $43,509
Crawford Co Health Dept $43,614
Dickinson Co Health Dept $37,333
Doniphan Co Health Dept $9,989
Douglas Co Health Dept $70,409
Edwards Co Health Dept $6,173

Ellsworth Co Health Dept $3,194
Finney Co Health Dept $130,208
Ford Co Health Dept $66,442
Franklin Co Health Dept $23,576
Geary Co Health Dept $98,173
Gove Co Health Dept B $2,910
Grant Co Health Dept $8,606
Gray Co Health Dept $5,016
Greeley Co Health Dept - $5,595
Greenwood Co Health Dept $7,656
Hamilton Co Health Dept $6,565
Harper Co Health Dept $5,782
Harvey Co Health Dept $44,798
Haskell Co Health Dept $7,306
Hodgeman Co Health Dept $3,363
Jefferson Co Health Dept $17,213
Johnson Co Health Dept $215,615
Kearny Co Health Dept $5,268
Kingman Co Health Dept $7,286
Kiowa Co Health Dept $5,303
Labette Co Health Dept $31,759
Lane Co Health Dept $4,990
Leavenworth Co Health Dept $70,992
Lincoln Co Health Dept $4,403
Linn Co Health Dept $13,004
Lyon Co Health Dept $73,899
Marion Co Health Dept $9,240
Marshall Co Health Dept $12,809
McPherson Co Health Dept $26,037
Meade Co Health Dept $4,409
Miami Co Health Dept $20,857
Mitchell Co Health Dept $13,521
Montgomery Co Health Dept $42,954
Morris Co Health Dept $4,699
Morton Co Health Dept $3,590
NEK (multi county) $92,645
Nemaha Co Health Dept $12,056
Neosho Co Health Dept $18,925
Osage Co Health Dept $14,864
Ottawa Co Health Dept $8,874
Pawnee Co Health Dept $5,904
Phillips Co Health Dept $9,341
Pottawatomie Co Health Dept $29,906
Pratt Co Health Dept $8,407
Rawlins Co Health Dept $2,165
Reno Co Health Dept $105,226
Republic Co Health Dept $6,763
Rice Co Health Dept $9,900
Riley Co Health Dept $115,225
Rooks Co Health Dept $48,751
Saline Co Health Dept $74,626
Scott Co Health Dept $3,221
Sedgwick Co Health Dept $581,317
SEK (multi county) $40,225
Seward Co Health Dept $88,831
Shawnee Co Health Dept $454,592

Sheridan Co Health Dept $2,802
Stafford Co Health Dept $5,875
Stanton Co Health Dept $3,903
Stevens Co Health Dept $6,389
Sumner Co Health Dept $24,896
Thomas Co Health Dept $15,895
Wabaunsee Co Health Dept $6,539
Washington Co Health Dept $9,015
Wilson Co Health Dept $11,167
Wyandotte Co Health Dept $698,918
CHC of SE Kansas $54,571
Hays Area Children's Center $18,156
Mercy Hospital $63,245

Teen Pregnancy Prevention Contracts for SFY 11 - totaling $356,694
defunded for SFY 2011

Teen Pregnancy Case Management Contracts for SFY 11 -- $460,670
defunded for SFY 2011, then $119,113 restored. Will be matched to Medicaid

School-Public Health Nurse Collaboratives for SFY 11 -- totaling $54,934
Reduction of $18,000 to $36,934 in 2010 session.

Pregnancy Maintenance Initiative contracts -- defunded and restored to $119,113 for SFY 11

SIDS Network of Kansas contract for SFY 11 -- $75,000

Women's Right to Know budget for SFY 11 -- $15,000 defunded

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.